Understanding Your Benefits

The City of Atlanta Retired Employee Enrollment Guide

September 1, 2014 – August 31, 2015

This Enrollment Guide Is Not A Contract

This guide provides a detailed summary of benefits available to City of Atlanta active employees and eligible dependents, as well as laws, procedures, and regulations required to obtain and use such benefits. However, if inconsistencies occur between the contents of this enrollment guide and the contracts, rules, or laws regulating administration of the various programs, the program contract terms and/or appropriate legislation supersede this guide. In some instances, limitations and exclusions may apply.

Should you have questions, please contact the benefit program's member services or the Department of Human Resources (DHR) Employee Benefits. Contact information is included in this booklet.

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City Of Atlanta Officials

Mayor Kasim Reed

Executive

Mayor ..... Kasim Reed

Legislative

President Of Council ..... Ceasar C. Mitchell

Members Of Council

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District 2 ..... Kwanza Hall
District 3 ..... Ivory Lee Young, Jr.
District 4 ..... Cleta Winslow
District 5 ..... Natalyn M. Archibong
District 6 ..... Alex Wan
District 7 ..... Howard Shook
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District 12 ..... Joyce M. Sheperd

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Post 2 At Large ..... Mary Norwood
Post 3 At Large ..... Andre Dickens

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Chief Operating Officer (Interim) ..... Michael Geisler
Chief Of Staff ..... Candace L. Byrd
Commissioner Of Human Resources ..... Yvonne Cowser Yancy

How To Use This Booklet

This book presents basic information about a wide range of benefit options available to you as an employee of the City of Atlanta. It provides a summary of key plan provisions so you can make an informed decision.

As you read this benefits booklet, you will find guidelines designed to help you analyze your benefits. If you cannot find the answers in this booklet, call your carrier and request additional information.

You should try to attend an Open Enrollment Meeting (see the schedule on page 6). Even if you already have coverage you may desire a better understanding of that coverage. This booklet helps you compare the plan options. It also explains how to adjust your coverage to reflect major life changes such as a new baby, marriage, divorce, leaving the City, retirement, and/or the death of a loved one.

Getting the Most From Your Benefits

This year, the City is offering one Health Maintenance Organization (HMO), one Point of Service (POS) and two Medicare Managed Care plans. Because of constant changes and the rising cost of health care, employees need more information regarding health and life insurance benefits in order to deal with the variety of choices you are asked to make. This booklet provides the information necessary to answer your benefits questions by offering a clear picture of all benefits provided by the City of Atlanta for you—the retiree. One of the first necessary steps to take is to learn which insurance plans your physician will accept in 2014–2015 and the provisions of your particular carrier. Once you understand your coverage, you will gain the confidence to take control of your benefits.

Health Terms

Various health care terms and options are defined and explained throughout this guide, such as “deductibles,” “coinsurance,” “reasonable and customary,” and more. You will find other definitions in the longer version of this booklet, available on The City’s website (www.atlantaga.gov).

Select Carefully

The information in this booklet offers the information that is essential to become an effective manager of your benefits. After all, who cares more about conserving your resources than you? Choices available are for the financial security of employees and their dependents. Please review your booklet thoroughly and read the directions for completing your 2014 – 2015 application before making your final selection. Remember, only you are capable of making the decision that best suits your needs.

Medical Plan Changes for FY15

BCBS POS

- **Deductibles increase by $100 ($400 individual/$1,200 family).**
- **Office visit copays increase by $5.00 ($20 PCP/$35 specialist).**
- **All medications with a generic equivalent will be filled as generic, unless the physician indicates DAW (dispense as written). Members who choose brand over the generic will pay the applicable copayment plus the difference in cost between the brand and generic.**
- **Annual out-of-pocket maximum established: In-network ($2,000 individual/$6,000 family), Out-of-network ($4,000 individual/$12,000 family)**

Kaiser HMO

- **Copay change for brand-name drugs: $40 Kaiser Pharmacy/$50 Network Pharmacy.**
- **The Kaiser Consumer Choice Option will not be offered in FY15.**

Important Contact Information

DHR - Employee Benefits 68 Mitchell St. SW Suite 2120 Atlanta, GA 30303 Phone: 404.330.6036 Fax: 404.658.6640	**Employee Wellness Center** 55 Trinity Ave SW 5TH Floor Atlanta, GA 30303 Phone: 404.865.8496 or 404.865.8497
GEM Group (General Pension Fund) 225 Peachtree St. Suite 1460 Atlanta, GA 30303 Phone: 404.525.4191 www.gemgrouplp.com	**Zenith American Solutions (Fire & Police Pension Fund)** 2187 Northlake Pkwy. Suite 106 Bldg. 9 Tucker, GA 30084 Phone: 770.934.3953 www.zenith-american.com
Pension Services 68 Mitchell St. SW Suite 2120 Atlanta, GA 30303 Phone: 404.330.6036	**Employee Assistance Program** 818 Pollard Blvd. Suite 301 B Atlanta, GA 30315 Phone: 404.658.7397

Benefits Providers

Blue Cross Blue Shield (POS) 1-800-368-0766 www.bcbsga.com	**Kaiser Permanente (HMO)** 1-888-865-5813 404-261-2590 www.kp.org
UnitedHealthcare Medicare Advantage Plan (PPO) 1-800-457-8506 www.UHCRetiree.com	**Kaiser Permanente Medicare Senior Advantage** (404) 365-0966 (800) 611-1811 www.kp.org
CIGNA Dental 1-800-244-6224 www.mycigna.com	**Humana Specialty Benefits Dental** 1-800-342-5209 www.humanaspecialtybenefits.com
UnitedHealthcare Vision 1-800-638-3120 www.myuhcvision.com	**AFLAC (Flex Spending & Supplemental Insurance)** 678-927-9578 www.aflac.com
Minnesota Life 1-866-293-6047 www.lifebenefits.com	**ING Deferred Compensation** 1-800-525-4225 www.ingretirementplans.com
ICMA Retirement Corporation 1-800-669-7400 www.icmarc.org	**Nationwide Retirement Solutions** 1-877-677-3678 www.nrstoru.com

Note To Medicare Participants

Special Note To Retirees

If you and/or your spouse are new enrollees to Medicare Parts A and B, you must attach a copy of your and/or your spouse's Medicare card to the Open Enrollment Application and enroll in either Kaiser Senior Advantage or UnitedHealthcare Group Medicare Advantage PPO.

If you live in the State of Georgia, the following selections are available for the plan year 09/01/2014 – 08/31/2015:

Kaiser Permanente will continue to offer SENIOR ADVANTAGE to retirees who have both parts A and B of Medicare and live within their Senior Advantage Service Area, which is offered in 20 counties in the metro Atlanta area.

If you are a current Kaiser Permanente Senior Advantage member, Kaiser Permanente will automatically serve as your Medicare Part D provider. If you are a new member who selects Senior Advantage as your retiree health care plan option for 2014 – 2015, your application will include Part D enrollment information. For additional information regarding this benefit, please call Kaiser Permanente Customer Service at 404-233-3700.

UnitedHealthcare Group Medicare Advantage PPO is offered to retirees and/or spouses who have both parts A and B of Medicare. The national network will include all providers accepting Medicare and willing to accept UnitedHealthcare Group Medicare Advantage PPO reimbursements and rules. To participate in the Medicare Advantage Plan, you will have to complete a separate application, which will be mailed to your home by the Employee Benefits Office. In the future, if you want to change from Medicare Advantage Plan to another Medicare Advantage Plan, you must notify the Employee Benefits office in writing.

If you have dependents (spouse or children) who are non-Medicare eligible and you sign up for UnitedHealthcare Group Medicare Advantage PPO, your dependents will be enrolled in the BCBS POS plan.

Please Note:

If you are Medicare eligible with a post-1986 hire date, you must enroll in Parts A and B of Medicare and enroll in a Medicare Advantage Plan. If you are not Medicare eligible, you may continue with the City's non-Medicare Plans.

If you sign up for any Medicare Advantage Plan (other than Senior Advantage offered by Kaiser or UnitedHealthcare Group Medicare Advantage PPO that may be offered to you directly by various vendors, including just Medicare Part D for prescription drugs, YOUR COVERAGE THROUGH THE CITY OF ATLANTA WILL BE TERMINATED. If you have any questions about this, please call the DHR – Employee Benefits at (404) 330-6036 before signing up for another medical plan of any type.

Open Enrollment Information

This year's Open Enrollment period for the City of Atlanta will be Monday, July 14 through Monday, July 28, 2014. The Medical, Dental, Vision, and Life plans offered in the new plan year are the same as the 2014 plan year.

Review the plan offerings, and select which programs you and your dependents would like to enroll in. The options you select will be effective September 1, 2014. The changes you make during the Open Enrollment period will remain in effect until August 31, 2015, unless you have a qualifying life event. If you do not wish to make changes for the new benefit plan year, you are not required to return an application. All Open Enrollment applications with benefit changes are due to the Department of Human Resources (DHR) Employee Benefits office no later than July 28, 2014. If you are completing the application online, Open Enrollment will close at 11:59 p.m. on July 28, 2014.

Online Self-Service Access

Online self-service open enrollment access is available at the City's website, www.atlantaga.gov. Online access and self-service enrollment assistance is available throughout the OE period, at City Hall Tower, DHR, Suite 2120. The Office of Employee Benefits staff is available weekdays from 8:30 a.m. to 5:30 p.m.

Attend an Open Enrollment (OE) Period Information Forum

Would you like to know more about your 2014 – 2015 benefits? The Employee Benefits office will be on location to answer your questions. Speak with the benefit program providers face-to-face at an OE Information Forum near you. The calendar below shows the dates and times for the Information Forums.

OE Period Events Calendar

July 2014

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
14 **2 City Plaza 2nd Fl. Auditorium** 10 a.m. – Noon 2 – 4 p.m.	**15** **Public Safety Bldg. JOC Conf. Rm.** 10 a.m. – Noon 2 – 4 p.m.	**16** **Public Safety Bldg. JOC Conf. Rm.** 10 a.m. – Noon 2 – 4 p.m.	**17** **City Hall Old Council Chambers** 10 a.m. – Noon 2 – 4 p.m.	18	**19** **Rosa Fann Rec Center Auditorium** 10 a.m. – 2 p.m.
21 **2 City Plaza 2nd Fl. Auditorium** 10 a.m. – Noon 2 – 4 p.m.	**22** **Airport Tech Center** 10 a.m. – Noon **Airport Gateway Conf. Rm.** 2 – 4 p.m.	**23** **Airport Tech Center** 10 a.m. – Noon	**24** **City Hall Old Council Chambers** 10 a.m. – Noon	**25** **Civic Center Piedmont Room** 2 – 4 p.m.	26
28	29	30	31	1	2

OE Information Forum Locations

- City Hall Old Council Chamber
  City Hall Tower
  68 Mitchell St. SW, 3rd Floor
  Atlanta, GA 30303
- Public Safety Headquarters
  JOC Conference Room
  226 Peachtree St.
  Atlanta, GA 30303
- 2 City Plaza, 72 Marietta St.
  2nd Floor Auditorium
  Atlanta, GA 30303
- Hartsfield-Jackson Airport
  Technical Center
  1255 South Loop Road
  College Park, GA 30337
- Hartsfield-Jackson Airport
  Gateway
  6000 N. Terminal Parkway
  4th Floor Atrium
  Boeing Cessna Conference Room
- Adamsville
  Auditorium 1
  3201 Martin Luther King Junior Dr. SW
  Atlanta, GA 30311
- Civic Center
  Piedmont Room
  395 Piedmont Avenue NE
  Atlanta, GA 30308
- Rosa Fann Rec Center
  365 Cleveland Avenue SE
  Atlanta, GA 30354

Eligibility

Benefits Eligibility

Retirees, their surviving beneficiaries, and their dependents are eligible to enroll in the City of Atlanta's health and dental plans. Dependents must meet certain eligibility criteria to be considered. The following is a list of eligible dependents:

- A spouse (a husband or wife who is joined in marriage to a retiree by a ceremony recognized by the laws of the State of Georgia)
- A domestic partner (registered with the City of Atlanta)
- A dependent child through 26 years of age (coverage ends at the end of the month the child reaches age 26)
- A legally adopted child under age 26 or a child for whom you have guardianship (permanent or deemed permanent for insurance purposes)
- A stepchild under age 26 permanently residing with the employee and supported by the employee
- A child under age 26 receiving court-ordered support
- A child 26 years or older who is incapable of self-support due to mental or physical disability; and who has a permanent disability
- A child, after attaining age 26, who is receiving a pension check as a surviving beneficiary and is covered by the City of Atlanta Group Plan must provide full-time student documentation. When eligibility for pension ends due to age or change in school enrollment status, contact the DHR – Employee Benefits at 404-330-6036 to continue coverage.
- As a surviving spouse, if you terminate coverage you will not be able to re-enroll in the City of Atlanta Benefits Plan.
- Documentation is needed if the retiree is adding a dependent or making changes in a dependent's status.
- If both you and your spouse are insured under a City of Atlanta health/dental plan as an employee or retiree, your children may be insured as dependents of either you or your spouse, for health/dental coverage.

No city employee/retiree may be the dependent of another employee/retiree for health, vision or dental insurance. However, for Life Insurance, you may cover a spouse/dependent even if the spouse is an employee/retiree. Children may be insured by both parents for life insurance coverage.

Please remember to submit supporting documentation when you add dependents. If the Employee Benefits office does not receive your documentation your dependents will not be added.

Dependent Eligibility Documentation Requirements

Dependents	Documentation Required
For Spouse	Copy of marriage certificate. If previously married, death certificate or divorce decree.
For Removal of Spouse/Child	None at Open Enrollment. Court decree **within 31 days** of decree during the contract year.
For Natural Child(ren)	Child's birth certificate (showing the parent-child relationship to employee/retiree and/or spouse).
For Adopted Child(ren)	Placement papers signed by the courts.
For Disabled Child (26 years and older)	Physician verification of permanent disability.
Foreign Adoptions	Adoption papers signed by the courts; visa showing date of entry to USA.
For Stepchild(ren)	Child's birth certificate (showing parent-child relationship with employee/retiree's spouse); copy of marriage certificate.
For Court-Ordered Support	State affidavit; copy of signed court order requiring employee/retiree to provide support for health coverage.
For Guardianship	Court ordered guardianship deemed permanent for insurance purposes.
For Domestic Partner	City of Atlanta Affidavit of Financial Reliance (notarized) within 31 days of approval.
For Termination of Domestic Partner	None at Open Enrollment; City of Atlanta Notice of Termination **within 31 days** of termination during the contract year.

Social Security number and date of birth must be provided for all dependents. Failure to submit the dependent's Social Security number will result in termination/denial of coverage (exceptions: newborns age six months or less).

Documentation also applies to life insurance coverage.

No documentation is required at Open Enrollment to delete a dependent.

All documentation should contain the employee's name and Social Security number.

Changes In Coverage

Change In Family Status

You may change your health and/or dental insurance coverage during the open enrollment period. You can also change your coverage during the year but only if the application to change coverage is submitted within 31 days of your family status change because of:

- marriage;
- divorce*;
- birth, legal adoption, placement for adoption or custody change of an eligible child;
- death of a spouse or eligible child, or a dependent's leaving the household as a result of a custody agreement; or
- changes in the spouse's employment which affects his/her eligibility for benefits under another employer's group benefits plan; or
- Part A or Part B of Medicare becomes effective.

**Anyone removed from the policy is entitled to COBRA (see COBRA Continuation Coverage).*

Coverage will be effective the date of the change in family status. An adjustment of the premium for the level of coverage change will be deducted from your paycheck. Ask your departmental payroll clerk for a Health Insurance Change Application. Both you and your spouse (if applicable) must sign the form. Return the form to your departmental payroll clerk.

Option Changes

Option changes are permitted only during the Open Enrollment period. Changes made during the Open Enrollment period become effective on September 1, 2014.

If you move out of the service area covered by the HMO in which you are enrolled, you must request a change to another plan within 31 days of your move or at the next Open Enrollment.

If a Plan listed in this brochure ceases operation, during the plan year, employees will have a choice to move to another plan.

If you decide to move to a different plan, you must do so at Open Enrollment, unless you determine that Kaiser SENIOR ADVANTAGE does not meet your needs. You may re-enroll (with 30 days prior notice) in one of the City Plans. Additionally, if you enroll in Part A and Part B of Medicare during the year, you should notify the Employee Benefits office. You may also change to Kaiser Senior Advantage at that time.

Surviving Beneficiaries

- A Surviving Beneficiary is eligible for coverage if they are eligible for pension benefits and were covered as dependents at the time of the employee's or retiree's death. A Surviving Beneficiary who terminates his/her coverage will not be eligible to return to the City Benefit Plan at any time in the future.
- A Surviving Beneficiary cannot add new dependents.
- A Surviving Beneficiary child must continue to submit full-time student statements to be eligible for coverage. When the child is no longer eligible for a pension check, he/she will be eligible for continuation of coverage under COBRA. Contact the DHR – Employee Benefits at (404) 330-6036.

Continuation of Coverage

Information about continuing health care coverage under COBRA is in the back of the booklet.

Remember that converted coverage may not be the same as group coverage, and will be available to you at the individual rate, not at the group rate. For additional information, call the respective insurance company/HMO.

The HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA), better known as the KASSEBAUM-KENNEDY LEGISLATION states:

If you cease to be an eligible dependent, or your COBRA eligibility terminates, A CERTIFICATE OF GROUP HEALTH PLAN COVERAGE will be mailed, by your Insurance Carrier/HMO to the last address on their file.

If you do not submit changes, you will be enrolled in your current coverage and you will not be allowed to change coverage from 09/01/2014 – 08/31/2015 unless there is a change in family status or you relocate out of the service area of the carrier.

Facts About Your Insurance

No Insurance

If you do not want health and/or dental insurance during 09/01/2014 – 08/31/2015, you must select NO COVERAGE using Self-Service or submit coverage changes on the enclosed Open Enrollment Application.

Coverage for Mental or Physically Disabled Dependent

To provide coverage for a dependent who is incapable of self-support because of a mental or physical incapacity, an employee must provide a completed Physician Verification of permanent disability. This form is available in the DHR - Employee Benefits.

Change of Address

You must submit a change of address to your Pension Plan Administrator or to the Department of Human Resources to correct the City of Atlanta records.

Pension Deductions

As a retiree, your share of health/dental insurance will be deducted from your pension check monthly. However, in the case of late Open Enrollments, deductions may be delayed. If this occurs, back premiums and/or refunds (if applicable) will be included in your pension check as soon as possible.

ID Cards

After your Open Enrollment Application is processed and an eligibility file is sent to each insurance carrier, your ID card and member booklet will be mailed to your home address by the selected insurance company. The ID card should be placed in your wallet for easy access at all times. Be sure to read the member booklet carefully, and keep it in a safe place for easy reference. The member booklet will provide detailed information on how to use your insurance benefits. You will not receive a new ID card unless you make a change in your coverage. Reimbursable claims should be filed only with your insurance carrier, not the City of Atlanta.

NOTE: All members will receive separate cards for dental and vision coverage. If you need medical care prior to receiving your new ID card, use a physician and/or hospital on your new Carrier list of providers.

Please provide a copy of your and/or your spouse's Medicare Part A and Part B.

PLEASE MAKE A COPY OF YOUR OPEN ENROLLMENT APPLICATION AND DOCUMENTATION THAT YOU SUBMITTED FOR YOUR RECORDS. ALWAYS PRINT YOUR NAME AND SOCIAL SECURITY NUMBER ON ALL DOCUMENTATION. MAKE A COPY AND ATTACH IT TO THE ENROLLMENT FORM.

Benefit Self-Service Instructions

Enrolling in Your COA Benefits Using Oracle Self Service

Benefits Open Enrollment can now be completed online! There are six main parts to this process and each is outlined in this step-by-step guide.

1. Access the OAB Website at **www.atlantaga.gov**
2. Click on **Departments**, then click **Human Resources**
3. Click on **Employee & Retiree Benefits**
4. Click on the **Open Enrollment (OE) Quick Link**
5. Enter your username: **Employee ID** and **Password** (*If you need an oracle password and your employee ID number please contact the help desk at 404-865-8949*).
6. In the navigator tool, click **COA Employee Self Service,** then click **Benefits**

Page 1: Dependents and Beneficiaries

This is where you will enter anyone you want to list as a dependent and or beneficiaries, if they are not there.

7. Click Add Another Person
8. Enter the person's **Name and Relationship.**
9. Enter their Address Information, or if they share the same residence as you, check the shared residence box.
10. Enter the Required Information.
11. When finished, click Apply
12. Repeat steps 7–10 as many times as necessary to add dependents and beneficiaries.
13. When you are ready to continue, click Next

Page 2: Benefits Enrollments

This page will show an overview of available benefits and your current status. To enroll move to step 14.

14. Click Update Benefits
15. Check the boxes ☑ Add Dependents and Beneficiaries next to the benefits you want to select. You can add dependents and beneficiaries at any time by clicking the button.
16. When you have made your selections and are ready to continue, click Next

Page 3: Update Benefits—Cover Dependents

This is where you will choose which dependents will be covered for your selected benefits.

17. Click on the box next to their name if you want them to be covered under this corresponding benefit.
18. When you have made your selections and are ready to continue, click Next

Page 4: Update Beneficiaries—Add Beneficiaries

This is where you can specify what percentage of any insurance payouts you want each of your beneficiaries to receive.

19. Choose which beneficiaries would receive anything as a primary recipient (for example, will your spouse receive 100% of the benefit if something happens to you)?
20. Choose which beneficiaries would receive anything as a contingent recipient (for example, what will your children receive if something happens to you and your primary recipient)?
21. To recalculate your total, click Recalculate Both the primary and contingent percentages should equal 100%.
22. Repeat for additional policies listed.
23. When you are ready to continue, click Next

Page 5: Add Primary Care Providers

24. Depending on the plans you have selected for your medical insurance, you may be asked to enter your primary care provider's ID, name and specialty.

25. When you are ready to continue, click Next

Page 6: Confirmation Page

This page allows you to review everything you have selected.

- If you want a printable version of this page, click Printable Page
- If you want a Confirmation Statement, click Confirmation Statement

26. When finished, click Finish

You will then see another review of what you have selected.

If you want to make any changes, click Update Benefits and follow from step 14.

You're Done!

Frequently Asked Questions

How do I enroll or update my information?

Visit the City's public website at www.atlantaga.gov. From the left navigation bar on your page, click on "Departments" – "Human Resources" – "Employee/ Retiree Benefits" home page. From the top navigation bar go to "How Do I…" – "Employee/ Retiree Benefits Home Page." Employees may also go directly to the Employee Self-Service application within Oracle to enroll.

What is my user name?

Your user name is your employee ID number. If you are a retiree, you may find this number on your pension check. If you cannot locate your employee ID number, please call the Help Desk at 404-865-8949. The Help Desk representative will ask a series of questions for validation purposes. The Help Desk will provide you with your user name, which is usually your employee ID number.

What is my password?

If you need a password reset, contact the help desk at 404-865-8949.

What do I do if I forget my password?

You need to call the Help Desk at 404-865-8949 to reset the password or click "Forgot Your Password" online from the "Employee/Retiree Benefits" Home Page. A valid COA email address is required.

I have not received my enrollment package. What do I do?

You can go online to www.atlantaga.gov and click on Departments – Human Resources – Employee/ Retiree Benefits and choose the link for Active Employees Benefits Booklet or Retiree Benefits Booklet. You may also email the Employee Benefits office at COABenefits@atlantaga.gov.

How much time do I have to enroll?

The Open Enrollment Period is from July 14, 2014 through midnight July 28, 2014 for all active and retired City of Atlanta employees. Because employees and retirees are enrolling online, you have access to the system 24 hours daily through July 28, 2014.

If I enroll online, what will I have for my records to prove I have enrolled or confirmed my benefits?

You can print a confirmation statement when you have completed your online enrollment.

What should I do if I do not have access to Oracle or if I do not see the "COA Employee Self Service" responsibility in my menu options when I log into the Oracle system?

Please call our Help Desk at 404-865-8949. The Help Desk will be able to authorize access.

Are there any major changes this year to be concerned about?

We consider this Open Enrollment as a passive enrollment period, which means that no significant changes were made to the Medical, Dental and Vision Plans.

However, you will see some changes to the BlueCross BlueShield POS plan, including the following:

- Deductibles increase by $100 ($400 individual/$1,200 family).
- Office visit copays increase by $5.00 ($20 PCP/$35 specialist).
- All medications with a generic equivalent will be filled as generic, unless the physician indicates DAW (dispense as written). Members who choose brand over the generic will pay the applicable copayment plus the difference in cost between the brand and generic.
- Annual out-of-pocket maximum established: In-network ($2,000 individual/$6,000 family), Out-of-network ($4,000 individual/$12,000 family).

What will be the effective dates of my new selections for coverage?

The option that you select will be effective September 1, 2014 and remain in effect until August 31, 2015 unless you have a qualifying life event. If there is a qualifying life event, you must enroll your dependent(s) within 31 days of the qualifying life event. Failure to do so may result in delayed benefits until Benefits Enrollment Period of 2015.

Am I required to make changes to my benefits?

If you do not wish to make changes for the new benefit plan year, you must confirm your benefit selections for the next plan year through Oracle Self-Service. **If you have dependents (spouse or children) who are non-Medicare eligible and you sign up for UnitedHealthcare Group Medicare Advantage PPO, your dependents will be enrolled in the BCBS POS plan.**

When does all information have to be submitted to the Employee Benefits office?

All Open Enrollment benefit changes are due to the Department of Human Resources (DHR) - Employee Benefits no later than July 28, 2014. If you are completing the application online, Open Enrollment will close at 11:59 p.m. July 28, 2014.

What are the time frames associated with my current coverage vs. new coverage plans?

Your current coverage continues through August 31, 2014. The next Coverage Plan Year is September 1, 2014 – August 31, 2015.

What is the worst that could happen if I don't comply with Open Enrollment period guidelines?

Benefit selections for the new plan year will default to your current plan selection.

Do you have directions for enrolling online?

Yes. Please reference this document: Self-Service Instructions

When will the Open Enrollment Meetings be held this year?

Please see the schedule of Open Enrollment Meetings on page 6.

What are considered Qualifying Life Events?

Qualifying Life Events include newborn children, marriage, divorce, domestic partners, dependent loss of coverage and leave-of-absence without pay.

2014–2015 Cost Of Health Coverage For Retirees

Retiree rates are calculated accordingly:

- If a retiree was hired prior to April 1, 1986, that retiree should pay the premium that is listed in the 30% column
- Anyone hired on or after April 1, 1986 but retired between September 2009 through August 31, 2010 should pay the premium that is listed in 40% column
- Anyone hired on or after April 1, 1986 but retired September 2010 forward should pay the premium listed in the 50% column

You and the City of Atlanta share the cost of your health insurance coverage. The cost of coverage varies from year to year. Your costs for health coverage for 2014 – 2015, effective September 1, 2014, are shown in the following tables.

Medical Plans

Blue Cross Blue Shield POS

	30%		40%		50%	
	Retiree Cost	**City Cost**	**Retiree Cost**	**City Cost**	**Retiree Cost**	**City Cost**
Monthly Rates – Without Medicare						
Retiree Only	$165.98	$387.28	$221.30	$331.96	$276.63	$276.63
Retiree and Child(ren)	$290.71	$678.32	$387.61	$581.41	$484.51	$484.51
Retiree and Spouse/Domestic Partner	$415.43	$969.34	$553.91	$830.86	$692.38	$692.38
Retiree and Family	$548.54	$1,279.92	$731.38	$1,097.07	$914.23	$914.23
Beneficiary Child(ren)	$165.98	$387.28	$221.30	$331.96	$276.63	$276.63
Widow(er) Only	$165.98	$387.28	$221.30	$331.96	$276.63	$276.63
Widow(er) and Child(ren)	$290.71	$678.31	$387.61	$581.41	$484.51	$484.51

United Healthcare Medicare Advantage*

	30%		40%		50%	
	Retiree Cost	**City Cost**	**Retiree Cost**	**City Cost**	**Retiree Cost**	**City Cost**
Monthly Rates **						
Retiree Only - Medicare	$81.27	$189.63	$108.36	$162.54	$135.45	$135.45
Retiree and Child(ren) - Medicare	$247.21	$576.81	$329.61	$494.41	$412.01	$412.01
Retiree and Spouse/Domestic Partner (1 Medicare)	$247.21	$576.81	$329.61	$494.41	$412.01	$412.01
Retiree and Spouse/Domestic Partner (2 Medicare)	$162.54	$379.26	$216.72	$325.08	$270.90	$270.90
Retiree and Family (1 Medicare)	$371.90	$867.77	$495.87	$743.80	$619.84	$619.84
Retiree and Family (2 Medicare)	$328.48	$766.44	$437.97	$656.95	$547.46	$547.46
Widow(er) Only - Medicare	$81.27	$189.63	$108.36	$162.54	$135.45	$135.45
Widow(er) and Child(ren) - Medicare	$247.21	$576.81	$329.61	$494.41	$412.01	$412.01

*Medicare Part A and Part B required.
**Non-Medicare dependents will be enrolled in BlueCross BlueShield POS.

Kaiser Permanente HMO						
	30%		40%		50%	
	Retiree Cost	City Cost	Retiree Cost	City Cost	Retiree Cost	City Cost
Monthly Rates – Without Medicare						
Retiree Only	$151.53	$353.57	$202.04	$303.06	$252.55	$252.55
Retiree And Child(ren)	$265.17	$618.74	$353.56	$530.35	$441.95	$441.95
Retiree And Spouse/Domestic Partner	$378.82	$883.91	$505.09	$757.64	$631.36	$631.36
Retiree And Family	$500.04	$1,166.76	$666.72	$1,000.08	$833.40	$833.40
Beneficiary Child(ren)	$151.53	$353.58	$202.04	$303.07	$252.56	$252.56
Widow(er) Only	$151.53	$353.58	$202.04	$303.07	$252.56	$252.56
Widow(er) And Child(ren)	$265.17	$618.74	$353.56	$530.35	$441.96	$441.96

Kaiser Permanente Senior Advantage Medicare*						
	30%		40%		50%	
	Retiree Cost	City Cost	Retiree Cost	City Cost	Retiree Cost	City Cost
Monthly Rates						
Retiree Only - Medicare	$66.60	$155.40	$88.80	$133.20	$111.00	$111.00
Retiree And Child(ren) - Medicare	$277.79	$648.18	$370.39	$555.58	$462.99	$462.99
Retiree And Spouse/Domestic Partner (1 Medicare)	$220.20	$513.79	$293.60	$440.39	$367.00	$367.00
Retiree And Spouse/Domestic Partner (2 Medicare)	$133.20	$310.80	$177.60	$266.40	$222.00	$222.00
Retiree And Family (1 Medicare)	$396.83	$925.93	$529.10	$793.66	$661.38	$661.38
Retiree And Family (2 Medicare)	$286.80	$669.19	$382.40	$573.59	$478.00	$478.00
Beneficiary Child(ren) - Medicare	$66.60	$155.40	$88.80	$133.20	$111.00	$111.00
Widow(er) Only - Medicare	$66.60	$155.40	$88.80	$133.20	$111.00	$111.00
Widow(er) And Child(ren) - Medicare	$277.79	$648.18	$370.39	$555.58	$462.99	$462.99

*Medicare Part A and Part B members must enroll in Kaiser Senior Advantage.

Dental Plans

CIGNA Dental – High Option

	30%		40%		50%	
	Retiree Cost	**City Cost**	**Retiree Cost**	**City Cost**	**Retiree Cost**	**City Cost**
Monthly Rates						
Retiree Only	$8.72	$20.36	$11.63	$17.45	$14.54	$14.54
Retiree And Child(ren)	$18.47	$43.11	$24.63	$36.95	$30.79	$30.79
Retiree And Spouse	$17.82	$41.58	$23.76	$35.64	$29.70	$29.70
Retiree And Family	$29.23	$68.19	$38.97	$58.45	$48.71	$48.71
Beneficiary Child(ren)	$18.47	$43.11	$24.63	$36.95	$30.79	$30.79
Widow(er) Only	$8.72	$20.36	11.63	$17.45	$14.54	$14.54
Widow(er) And Child(ren)	$18.47	$43.11	$24.63	$36.95	$30.79	$30.79

CIGNA Dental – Low Option

	30%		40%		50%	
	Retiree Cost	**City Cost**	**Retiree Cost**	**City Cost**	**Retiree Cost**	**City Cost**
Monthly Rates						
Retiree Only	$8.49	$19.82	$11.32	$16.99	$14.16	$14.16
Retiree And Child(ren)	$16.43	$38.33	$21.90	$32.86	$27.38	$27.38
Retiree And Spouse	$17.28	$40.32	$23.04	$34.56	$28.80	$28.80
Retiree And Family	$26.09	$60.88	$34.79	$52.18	$43.49	$43.49
Beneficiary Child(ren)	$16.43	$38.33	$21.90	$32.86	$27.38	$27.38
Widow(er) Only	$8.49	$19.82	$11.32	$16.99	$14.16	$14.16
Widow(er) And Child(ren)	$16.43	$38.33	$21.90	$32.86	$27.38	$27.38

Humana Dental – Dental Access Managed Care

	30%		40%		50%	
	Retiree Cost	**City Cost**	**Retiree Cost**	**City Cost**	**Retiree Cost**	**City Cost**
Monthly Rates						
Retiree Only	$4.86	$11.34	$6.48	$9.72	$8.10	$8.10
Retiree And Child(ren)	$9.43	$22.01	$12.58	$18.87	$15.72	$15.72
Retiree And Spouse	$9.91	$23.12	$13.21	$19.82	$16.52	$16.52
Retiree And Family	$14.99	$34.98	$19.99	$29.99	$24.99	$24.99
Beneficiary Child(ren)	$9.43	$22.01	$12.58	$18.87	$15.72	$15.72
Widow(er) Only	$4.86	$11.34	$6.48	$9.72	$8.10	$8.10
Widow(er) And Child(ren)	$9.43	$22.01	$12.58	$18.87	$15.72	$15.72

Humana Dental – DHMO	30%		40%		50%	
	Retiree Cost	City Cost	Retiree Cost	City Cost	Retiree Cost	City Cost
Monthly Rates						
Retiree Only	$3.11	$7.25	$4.14	$6.22	$5.18	$5.18
Retiree And Child(ren)	$5.65	$13.18	$7.53	$11.30	$9.42	$9.42
Retiree And Spouse	$6.18	$14.41	$8.24	$12.35	$10.30	$10.30
Retiree And Family	$9.57	$22.33	$12.76	$19.14	$15.95	$15.95
Beneficiary Child(ren)	$5.65	$13.18	$7.53	$11.30	$9.42	$9.42
Widow(er) Only	$3.11	$7.25	$4.14	$6.22	$5.18	$5.18
Widow(er) And Child(ren)	$5.65	$13.18	$7.53	$11.30	$9.42	$9.42

Vision Plan

United Healthcare – Vision	Retiree Cost	City Cost
Monthly Rates		
Retiree Only	$4.28	$0
Retiree And Child(ren)	$9.40	$0
Retiree And Spouse	$8.95	$0
Retiree And Family	$12.10	$0
Beneficiary Child(ren)	$5.13	$0
Widow(er) Only	$4.27	$0
Widow(er) And Child(ren)	$9.40	$0

Wellness At Work

The Department of Human Resources manages a comprehensive health and wellness program for the City's active and retired employees and their families. For more info on the activities listed below contact the Employee Benefits office at 404-330-6036.

You should also log on to your healthcare provider's website and complete a Health Risk Assessment form. The assessment will assist you in determining which activity will suit your health care needs.

Kaiser Members: www.kp.org

Blue Cross Blue Shield Members: www.bcbsga.com

Employee Fitness Center

These free, state of the art fitness centers are located at various City facilities. These facilities have modern cardio-vascular and weight equipment machines and aerobic equipment. Some of the facilities have locker rooms and showers available.

Lunch and Learn Series

DHR, in partnership with contracted health insurance vendors and community providers, sponsors a monthly lunch and learn series for employees. Monthly topics focus primarily on key health issues identified by the American Medical Association and the National Institutes of Health. Health insurance vendors provide nutritious lunches while employees discuss various medical concerns with leading medical professionals. Topics include breast cancer, cardiovascular health, HIV/AIDS awareness, blindness prevention, diabetes prevention and management, nutritious foods and healthy cooking, fitness training, and dental care.

Disease Management

Contracted insurance vendors manage chronic diseases such as diabetes, heart disease, coronary artery disease (including circulatory restrictions and strokes), musculoskeletal disorders (including lower back pain) and digestive disorders (the top five chronic diseases prevalent in our population). The department is working to reach not only active employees but also partnering with other agencies to reach out to retired employees. At the same time, DHR is educating employees to help them be more aware of these illnesses and the health disparities leading to earlier and more frequent prevalence of these diseases.

Health and Wellness Programs

The City will offer these programs during the 2014 – 2015 benefit plan year.

- Weight Management Program
- Line Dancing Classes
- Citywide Stress Reduction Program
- Employee Daily Step Challenge Program
- Personal Fitness Trainers and Corporate Challenge Fitness Program
- Tai Chi and Zumba
- BCBS POS and Kaiser HMO retirees only can earn a rebate for completing an online Health Risk Assessment (HRA), Annual Physical Examination, and Biometric Screenings. All HRA/Biometric Screenings must be completed by November 30, 2014, to be eligible for the $100 rebate.
- Retiree Health Fair

Non-Medicare Retiree Health Plan Comparison

The chart below highlights key features and benefits under the BlueChoice POS and Kaiser HMO health plan options. See the plan summaries following this chart and the Summary Plan Descriptions for more details.

Plan Provisions	BlueChoice POS		Kaiser HMO
	In-Network	Out-of-Network	
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Deductible (individual/family)	$400/$1,200	$800/$2,400	$400/$1,200
Annual Out-of-Pocket Maximum (individual/family)	$2,000/$6,000	$4,000/$12,000	$2,000/$6,000
Coinsurance	100%	70%	N/A
Preventive Care			
Immunizations	100% (no copay)	70% after deductible	100% (no copay)
Pap Smear/Mammography/ Prostate Screening	100% (no copay)	70% after deductible	100% (no copay)
Routine Physicals	100% (no copay)	70% after deductible	100% (no copay)
Office Visits			
Primary Care	$20 copay	70% after deductible	$15 copay
Specialist	$35 copay	70% after deductible	$30 copay
Emergency Services	$150 copay (waived if admitted)		
Inpatient Hospital	100% after deductible	70% after deductible	100% after deductible
Outpatient Hospital Services • Hospital charges • Diagnostic X-ray/lab services • Physician services	100% after deductible	70% after deductible	100% after deductible
Mental Health/Substance Abuse			
• Inpatient facility and physician fee • Inpatient substance abuse detoxification facility and physician fee • Partial hospitalization program	100% after deductible	70% after deductible	100% after deductible
Outpatient Mental Health Treatment	$20 copay (unlimited visits)	70% after deductible	$15 copay (unlimited visits)
Ambulance Service	100% after $150 copay	70% after deductible	$150 copay
Skilled Nursing Facility (100 day max)	100% after deductible	70% after deductible	No Charge
Home Health Care	100% after deductible (40 visits per year max)	70% after deductible	No Charge (120 visits max)
Hospice Care	100% after deductible	70% after deductible	No Charge
Prescription Drugs			
Generic (30-day supply)	$10	70% after deductible	$10 KP/$20 NWK
Preferred Brand (30-day supply)	$25	70% after deductible	$40 KP/$50 NWK
Non-Preferred Brand (30-day supply)	$40	70% after deductible	N/A
Mail Order (90-day supply)	2x retail copay	Not covered	2x retail copay
Vision			
Eye Exam (every 12 months)	$35 copay	70% after deductible	$30 copay
Frames and Lenses (every 24 months)	Discount plan	Discount plan	Discount plan

*BlueChoice POS covers intensive outpatient mental health/substance abuse programs at 100%.

Terms You Should Know

Coinsurance: The fixed percentage of covered charges you must pay after any deductible has been subtracted. For example, if a plan pays 80 percent of covered charges (after applying any deductible), you would be responsible for the deductible and the 20 percent balance.

Copayment: A fixed dollar amount you must pay for a service or benefit provided by a plan..

Deductible: The amount of covered charges you must pay before the plan pays benefits, for example, calendar-year deductible and inpatient hospital deductible. Generally, no more than two or three family members must meet the calendar-year deductible. However, some plans have a family calendar-year deductible, which can be met by any or all of those covered.

Exclusions: Charges, services, or supplies that are not covered. A plan does not provide or pay for excluded items, nor do charges for them apply toward deductibles and catastrophic limits.

Reasonable and Customary: A maximum payment allowed for a given medical service based on a statistical formula calculated by an insurance company to determine the amount it will pay on a given medical service.

BlueChoice POS Plan Benefits Summary

09/01/2014 – 08/31/2015

Primary Care Physician

A primary care physician, or PCP, is a doctor who specializes in family or general practice, internal medicine or pediatrics and participates in the BlueChoice Option network. Each BlueChoice Option member must select a PCP. Your PCP is responsible for providing or coordinating necessary care for you 24 hours per day, 7 days a week. For additional medical information call BlueChoice On-Call, available 24 hours per day, 7 days a week.

BlueCross BlueShield of Georgia will designate a PCP for you if you do not list one on your Enrollment Application. You may change your PCP by notifying BlueCross BlueShield of Georgia. If notification is received prior to the 25th of the month, the PCP will change on the 1st of the following month. Notification after the 25th will delay the change a month.

In-Network versus Out-of-Network

As a BlueChoice Option member, you have the ability to receive services either from providers in the BlueChoice Option network or outside this network. Generally, you will pay less out of your own pocket if you elect in-network services.

- ***In-Network Services*** are those services that are either provided or coordinated by your PCP. Some services do not require PCP coordination. Please keep in mind that even though a referral is not required for certain services, you must select a provider from the network directory to receive in-network benefits. Services that do not require a PCP referral include:
  - *OB/GYN services* for the treatment of an obstetrical or gynecological-related condition.
  - *Covered vision care services* from a network ophthalmologist or optometrist (Routine vision services may not be covered under your policy – if you do not know if you have routine vision coverage, please call customer service at **(800) 368-0766**.
  - *Dermatological care* for skin-related conditions.
  - *Mental Health or Substance Abuse Benefits* – You may contact Blue Cross/ Blue Shield of Georgia Behavioral Health directly at **(800) 368-0766** without contacting your PCP.

Pre-Existing Condition Limitation and Credit for Prior Coverage

There is no pre-existing condition limitation.

Preventive Care

Preventive care visits are covered at 100% with no copay and no deductible. They include:

- Well-child care and immunizations
- Periodic health examinations
- Annual gynecological examination (no PCP referral required; must use in-network provider for in-network benefits)
- Prostate screening

Emergencies

If you have a medical emergency, call 911 or proceed immediately to the nearest hospital emergency room. A "medical emergency" is defined as, "a condition or recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in their health being in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ."

Prescription Drugs

BlueChoice Option offers prescription drug coverage through a pharmacy network that includes many national pharmacy chains and select local pharmacies. Coverage is provided according to our preferred drug formulary for prescriptions written by a network physician and filled at a network pharmacy. Out-of-network prescriptions are also subject to the preferred drug formulary.

Medications with a generic equivalent will be filled as generic unless the physician indicates DAW (dispense as written). If DAW is not indicated, members who choose the brand over the generic will pay the applicable copayment plus the difference in cost between the brand name and the generic. All specialty medications must be filled through the Mail Order service.

Summary of Limitations and Exclusions

Your Summary Plan Description will provide you with complete benefit coverage information. Some key limitations and exclusions, however, are listed below:

- Care or treatment that is not medically necessary
- Cosmetic surgery, except to restore function altered by disease or trauma
- Dental care and oral surgery; except for accidental injury to natural teeth, treatment of TMJ and extraction of impacted teeth
- Routine physical examinations necessitated by employment, foreign travel or participation in school athletic programs.
- Occupational related illness or injury
- Treatment, drugs or supplies considered experimental or investigational
- Surgical or medical care for: artificial insemination, invitro fertilization, reversal of voluntary sterilization, radial keratotomy, learning disabilities, mental retardation, hyperkinetic syndrome or autistic disease of childhood
- Smoking cessation products

Prior Authorization

Your PCP must coordinate most in-network services. For in-network services, your PCP (or the specialist to whom you were referred by your PCP) will be responsible for ensuring that any surgical procedures or inpatient admissions obtain the necessary prior authorization. For out-of-network services, you should be sure that Blue Cross Blue Shield Healthcare Plan of Georgia has authorized the following procedures prior to these services being rendered:

- Home health care services
- All outpatient surgery, including laproscopic and arthroscopic procedures
- Durable Medical Equipment over $250
- MRIs
- EMGs
- All scopes, including endoscopy and colonoscopy
- Myelography
- Cardiac catheterization

Note: This list is subject to change.

If you receive out-of-network treatment and prior authorization was not obtained, all charges will be denied. You, the member, will be responsible for all charges.

Vision

The coverage will be limited to one (1) eye examination for corrective lenses per member in a 12-month period, (corrective lenses include contacts as well as glasses). Office visit co-payment should be the same as for any other specialist $35.00 in-network and 70% of UCR, after the deductible, out-of-network.

The City will not cover lenses, frames, disposable or hard contact lenses and POS Members are encouraged to utilize the BCBS discounted vision program.

Additional Information

Should you need additional information, the resources are your Provider Directory/Member Guide and your Summary Plan Description. You may also visit our web site at www.bcbsga.com for more information. If you have specific questions that require an answer from our representatives, please call one of the following numbers:

- Customer Service: (800) 368-0766
- Blue Cross/Blue Shield of Georgia Behavioral Health (Mental Health/Substance Abuse Services): (800) 368-0766
- BlueChoice On-Call: (888) 724-2583

See Summary Plan Description for complete details.

It is important to keep in mind that this material is a brief outline of benefits and covered services and is not a contract. Please refer to your Summary Plan Description for a complete explanation of covered services, limitations and exclusions.

Wellness Programs Through Blue Cross Blue Shield

We continue to emphasize and encourage you and your family to both practice preventive care and take advantage of the 360° Health programs for maintaining your health. 360° Health® from Blue Cross and Blue Shield of Georgia (BCBSGa) is a total health solution that surrounds you with an integrated suite of resources and health programs designed to give you the information and support you need to reach your own level of optimal wellness. From Web-based resources to personalized interactions with registered nurses, 360° Health can help you become more engaged in your health care decisions that are right for you.

BCBSGa's **360º Health** program is designed to help you better manage your health. It is about your health and well-being, and represents the ways to support you in your personal focus on health.

Some of the exciting resources BCBSGa are making available to you include:

- **ConditionCare programs*** – For eligible employees and their dependents diagnosed with asthma (pediatric & adult), chronic obstructive pulmonary disease (COPD), heart failure (HF), coronary artery disease (CAD) or diabetes (pediatric & adult). To register simply call 1-800-638-4754.
  **For the ConditionCare programs, a nurse may proactively initiate telephone calls throughout the year to determine if you or a covered family member might benefit from the program. We begin to support you and your physicians care plan. Of course, participation in the program is completely voluntary and confidential.*
- **24/7 NurseLine** – Talk with a registered nurse anytime! Simply call 1-888-724-2583 (also located on your BCBSGa insurance card) (Hint: program this number into your cell phone)
- **Future Moms** – Your start to a healthy pregnancy…please join this award winning maternity management program for great information, support and materials! Register today: 1-866-664-5404.
- **Healthy Lifestyles** – Online and coaching for a healthier life! This lifestyle program focuses on Tobacco Use, Exercise, Weight Management, Self Care, Stress Management, Nutrition, Depression Prevention, Medication Adherence.
- **MyHealth Assessment** – A health risk appraisal that can be completed online www.bcbsga.com—$50 gift card for completion of health risk assessment (HRA).
- **Healthy Living** – A trusted health information resource powered by WebMD and brought to us for no charge as BCBSGa members
- **Anthem Care Comparison** – A tool that will allow you to compare health care providers, treatment options and pharmaceutical products

- **Special Offers** – A discount program for you that will give you access to a wide variety of services and products like fitness club memberships, Weight Watchers® & Jenny Craig®—the list goes on and on. To access these discounts simply go to www.bcbsga.com

We hope that these free and confidential resources will help you and your families to become healthier and improve your view on health! Please feel free to call or go online. To access the online tools simply register one time at www.BCBSGa.com to create your own user name and password (to register please have your BCBSGa insurance card – the only time you will need it).

Kaiser Permanente HMO User Guide (Non-Medicare Eligible)

009/01/2014 – 08/31/2015

Good Health is in our DNA.

For more than 60 years, our message has remained the same: Promote health to prevent illness. This apple-a-day approach helps foster the wellness of our millions of members nationwide.

But we're not just about ensuring health. We want to inspire it. Through care that's personalized to your goals and needs, intuitive technology that brings you closer to your well-being, and a mission that has stood the test of time.

Some people might say, "At least you have your health." At Kaiser Permanente, we prefer to see things this way: If you have your health, you have everything.

Get the Most Out of Your Health Plan

- **24-hour nurse advice:** Our nurses are here for you 24/7. For general questions, or urgent advice, please contact us at (404) 365-0966 or (800) 611-1811.
- **Specialties:** We've added even more specialties to our growing list of services. Go to www.kp.org to see which specialties are available at each of our medical facilities.
- **Strive to Thrive:** Wellness Coaching by Phone: Whether you want to eat healthy, quit tobacco, manage your weight, exercise more, or reduce stress, our wellness coaches can help you find ways to succeed. Wellness coaching is done over the telephone and offered to members at no cost. Call (866) 862-4295 to get started.
- **Healthworks wellness plan:** $50 gift card for completion of the Total Health Assessment. $150 gift card for completion of your annual physical.
- **Urgent care:** If you are considering going to the ER and don't have a life-threatening illness or injury, call us and we may be able to take care of you more quickly and at a lower out-of-pocket cost to you. Our urgent care centers offer an alternative to the emergency room when your injury needs immediate medical attention but is NOT a medical emergency.

  Kaiser Permanente Urgent Care Centers

  Adult: Monday – Friday, noon to 10 p.m.; Saturday and Sunday, 10 a.m. to 6 p.m.

  Pediatrics: Monday – Friday, 6 pm. to 8 p.m.; Saturday and Sunday, 10 a.m. to 6 p.m. (Panola Medical Center: 10 a.m. to 2 p.m.)

  - Townpark Comprehensive Medical Center, 750 Townpark Lane, Kennesaw, GA 30144
  - Southwood Medical Center, 2400 Mt. Zion Parkway, Jonesboro, GA 30236
  - Panola Medical Center, 5400 Hillandale Drive, Lithonia, GA 30058
  - Gwinnett Comprehensive Medical Center, 3650 Steve Reynolds Boulevard, Duluth, GA 30096

Preventive Care

Preventive care visits are covered at 100% with no copay and no deductible. They include:

- Immunizations
- Well-child physicals
- Annual adult physicals
- Annual gynecological examination
- Mammograms
- Prostate screening

Where do I receive medical care?

When you join Kaiser Permanente, you pick your own personal physician from the group of doctors practicing at any of our medical centers. Currently, Kaiser Permanente has 26 conveniently located medical centers throughout metro Atlanta: Alpharetta, Brookwood at Peachtree, Cascade, Crescent, Cumberland, Decatur, Douglasville, East Cobb, Conyers, Fayette, Forsyth, Glenlake, Gwinnett, Henry, Holly Springs, Lawrenceville, Newnan, Panola, Peachtree Center, Snellville, Southwood, Sugar-Hill Buford, TownPark, West Cobb, West Marietta, and Stonecrest.

For a listing of the providers covered under the Kaiser Permanente plan, please visit us online at www.kp.org.

How do I choose or change my primary care physician?

We ask you to choose a personal physician upon enrollment so that you and your doctor can develop a partnership and work together to make sure you get the quality care you deserve. Your personal physician will guide and coordinate any care you receive in the hospital or from specialists. And having one doctor who arranges your care and knows your medical history helps you get the right care from the right people. The relationship you build with your personal physician can help you achieve and maintain both good health and good spirits.

You may choose a physician in family medicine, general practice, adult medicine or pediatrics/adolescent medicine as a personal physician.

How do I make an appointment?

It's really easy. There is one number to call to make or cancel appointments, speak with an advice nurse, or access after-hours urgent care—regardless of which Kaiser Permanente Medical Center you use. Call the Health Line at (404) 365-0966 locally or (800) 611-1811 long distance.

To schedule or cancel appointments, you may call Monday through Friday from 7 a.m. to 7 p.m. The Health Line is open to speak with an advice nurse 24 hours, seven days a week. You may also schedule and cancel appointments yourself by logging into our website at www.kp.org.

What if I need to see a specialist?

As a Kaiser Permanente member, you have direct access to Audiology, Behavioral Health, Breast Care, Cardiology, Dermatology, Endocrinology, Gastroenterology, General Surgery, Infectious Disease, Nephrology, Neurology, Obstetrics/Gynecology, Oncology, Otolaryngology (ENT), Perinatology, Podiatry, Psychiatry, Pulmonology, Rheumatology, Urogynecology, Urology, Wound Care, and Pain Management.

No referral is required for specialty services available at the Kaiser Permanente Medical Centers. A referral is required for specialty care outside of a Kaiser Permanente Medical Center.

What if I need to be admitted to the hospital?

Kaiser Permanente is affiliated with some of Atlanta's most prestigious hospitals. The personal physician you choose will determine the hospital to which you will be admitted. The hospitals used for most inpatient care are: Children's Healthcare of Atlanta at Scottish Rite, Northside Hospital, and Piedmont Hospital.

Get Connected.

Take a minute to register on www.kp.org and enjoy the 24-hour convenience of these secure online features:

- Order prescription refills*
- Request or cancel routine doctors' appointments*

- Get personalized plans for losing weight, managing stress, and eating healthy
- Online total health assessment as well as healthy living classes

You'll also have online access to these new, timesaving features:*

- E-mail your doctor's office
- View certain lab tests results
- Monitor your ongoing health conditions
- Review past office visit information
- And more!

It's simple. To register, visit www.kp.org/register.

*Available for members receiving care/refilling prescriptions at Kaiser Permanente medical centers.

What should I do if I need Emergency Care?

If you have an emergency, call 911 or go to the nearest emergency room.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part
- serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child

If you are hospitalized, you should call (or have someone else call) the Kaiser Permanente Health Line—(404) 365-0966 locally or (800) 611-1811 long distance—to notify us of your hospital admission as soon as you can within 24 hours of your admission. This will allow us to consult with the physician providing your care and to coordinate further medical care.

You will pay a $150 copayment for emergency room services. (Emergency fees are waived if you're admitted.) Students attending school outside of the Kaiser Permanente service area will be covered for up to $1,000 for follow-up care associated with emergency services. You are responsible for 20% of the cost up to $1,000 for follow-up emergency care.

Do I fill out claim forms?

There are no claim forms required if care is provided, prescribed, or directed by a Kaiser Permanente physician. If there is a copayment, coinsurance, or deductible, you will be expected to pay at the time you receive the services.

If you have any questions about claims, please call a Claims Services Representative at (404) 365-0966.

What if I have additional questions?

Call Customer Services at (404) 365-0966 locally or (800) 611-1811 long distance. You can also visit our website at www.kp.org.

Summary of Limitations and Exclusions

Your Group Agreement or Evidence of Coverage will provide you with complete benefit coverage information. Some key limitations and exclusions, however, are listed below.

- Services that are not medically necessary
- Certain exams and other services required for obtaining or maintaining employment or participation in employee programs or required for insurance or licensing, or on court order or for parole or probation
- Cosmetic services
- Custodial or intermediate care
- Services that an employer or a government agency is required by law to provide
- Experimental or investigational services
- Eye surgery, including laser surgery, to correct refractive defects
- Services for conditions arising from military service
- Services related to the treatment of morbid obesity (except certain health education programs are covered)
- Routine foot care
- Sexual reassignment services
- Reversal of voluntary sterility
- Conditions covered by workers' compensation or under employer liability law

Medicare Plans

IMPORTANT NOTICE FROM THE CITY OF ATLANTA ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Atlanta and new prescription drug coverage first available January 1, 2006 for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. Starting January 1, 2006, new Medicare prescription drug coverages were made available to everyone with Medicare.
2. The City of Atlanta has determined that the prescription drug coverage offered by UnitedHealthcare and Kaiser are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay for the period September 1, 2014 – August 31, 2015.
3. Read this notice carefully—it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll. Anyone with Medicare can enroll in a Medicare prescription drug plan from November 15 through December 31, each year with no penalty. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later.

IF YOU ENROLL IN ANY ADDITIONAL MEDICARE PRESCRIPTION DRUG PLAN, YOUR COVERAGE WITH THE CITY OF ATLANTA WILL BE TERMINATED. FOR FURTHER INFORMATION, CONTACT 404-330-6036.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay an extra penalty if you later decide to enroll in Medicare coverage.

For more information about this notice or your current prescription drug coverage:

Contact the Employee Benefits office for more information at (404) 330-6036.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage can be found in the following places:

- visit www.medicare.gov for personalized help;
- call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number); or
- call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage after May 15. 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

PLEASE NOTE: If you sign up for any Medicare Advantage Plan (other than Senior Advantage offered by Kaiser or UnitedHealthcare Group Medicare Advantage PPO that may be offered to you directly by various vendors, YOUR COVERAGE THROUGH THE CITY OF ATLANTA WILL BE TERMINATED. If you have any questions about this, please call the DHR – Employee Benefits at (404) 330-6036 before signing up for another plan.

Medicare Medical Plan Comparison Chart

The chart below highlights key features and benefits under the UnitedHealthcare Group Medicare Advantage and Kaiser Senior Advantage (HMO) health plan options. See the plan summaries following this chart and the Summary Plan Descriptions for more details.

Plan Provisions	**UnitedHealthcare Group Medicare Advantage PPO** In-Network/Out-of-Network	**Kaiser Senior Advantage**
Lifetime Maximum	Unlimited	Unlimited
Deductible (individual/family)	$0 / $0	N/A
Annual Out-of-Pocket Maximum (individual/family)	$3,350 / N/A	$3,000 / $9,000
Preventive Care		
Immunizations	100% (no copay)	100% (no copay)
Pap Smear/Mammography/ Prostate Screening	100% (no copay)	100% (no copay)
Routine Physicals	100% (no copay)	100% (no copay)
Office Visits		
Primary Care	$15 copay	$10 copay
Specialist	$25 copay	$30 copay
Emergency Services	$50 copay (waived if admitted)	
Inpatient Hospital	$250 copay per admission, $750 Annual Out of Pocket Maximum. (included in the $3,350 Annual Out of Pocket Maximum)	$200 copay per admission
Outpatient Hospital Services • Hospital charges • Diagnostic X-ray/lab services • Physician services	$100 copay for hospital charges; no charge for physician services	$100 copay for hospital charges; no charge for physician services
Mental Health/Substance Abuse No PCP referral required.		
Inpatient Mental Health Treatment	Plan pays 100% (unlimited visits)	$200 copay (unlimited days)
Outpatient Mental Health Treatment	Plan pays 100% (unlimited visits)	$10 copay (unlimited days)
Ambulance Service	$100 copay	$100 copay
Skilled Nursing Facility (100 day max)	$0 copay	$0 copay
Home Health Care	$0 copay	$0 copay (120 visits max)
Hospice Care	$0 copay	$0 copay
Prescription Drugs		
Generic (30-day supply)	$10	$10
Preferred Brand (30-day supply)	$20	$30
Non-Preferred Brand (30-day supply)	$40	N/A
Mail Order (90-day supply)	2x retail copay	2x retail copay
Vision		
Routine Eye Exam (every 12 months)	$15 copay	$30 copay
Frames and Lenses Allowance (every 24 months)	$130 credit	$100 credit (frames, contacts)
Service Area	Any provider who participates in Original Medicare and agrees to the terms and conditions of UnitedHealthcare Group Medicare Advantage PPO.	Barrow, Bartow, Butts, Cherokee, Clayton, Cobb, Coweta, Dekalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Newton, Paulding, Rockdale, Spalding, and Walton Counties

UnitedHealthcare Group Medicare Advantage PPO Plan

09/01/2014 – 08/31/2015

This plan offers the flexibility you deserve and predictable health coverage with options to fit your needs. This plan can help bring you the peace of mind that comes from knowing you're in good hands.

More people trust their Medicare coverage to UnitedHealthcare than any other company. We are happy to have you as a member.

With this PPO plan you pay the same copay or coinsurance whether you see a provider in or out of network. You have the flexibility to choose your own doctor, hospital or specialist as long as they participate in Medicare and accept the plan.

With our large network, there is a good chance your doctor is already part of our plan. You can find doctors and hospitals by searching our online directory or calling customer service.

Benefits for Retirees

This plan provides a rich plan design and predictable costs with value-added programs and services. Benefits for retirees include:

- Richer coverage than Original Medicare Parts A and B
- Access to our national Medicare Advantage network of more than 420,000 health care providers
- Limits to annual out-of-pocket expenses
- The convenience of one ID card for both medical and prescription drug coverage
- Coverage for retirees who travel or have a seasonal residence anywhere in the United States.
- Valuable additional services, such as NurseLine, disease management and wellness programs at no additional charge.

This Preferred Provider Organization (PPO) plan gives you the freedom to go to any doctor or other licensed medical professional that accepts Medicare, anywhere in the United States. The provider does not have to be part of the UnitedHealthcare network.

You have the flexibility to see providers in or out of network. You pay the same copay or coinsurance whether your provider is in or out of network.

For help in finding a network provider, call Customer Service at the number listed on the back of your ID card or view our online directory at www.UHCRetiree.com.

Customer Care

With a sole focus on service to Medicare plan members, our customer care professionals are trained on the unique needs of our retirees.

Our customer care professionals are skilled in addressing a broad array of topics such as:

- Plan benefits and coverage levels
- Our value-added benefits, programs and services
- Provider networks and assisting in finding a provider
- Issue resolution

Finding a United Healthcare Medicare Advantage Provider

Visit www.myuhcretiree.com to locate a UnitedHealthcare Group Medicare Advantage PPO provider or call Customer Service at the number listed on the back of your ID card.

Identification Cards

You will receive a UnitedHealthcare ID card for coverage that includes hospital stays, doctor visits, prescription drugs, and more.

Additional Benefits

Take advantage of the extra programs and services available with this PPO plan.

Please note: the valued added products and services described on this page are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the UnitedHealthcare grievance process.

NurseLine Services

NurseLine services by UnitedHealthcare are available 24 hours a day, 7 days a week, at no additional cost to you.

Nurseline's registered nurses focus on finding you the right care, right provider, right medication and the right lifestyle.

Registered nurses can help you:

- Find a doctor
- Discuss treatment options
- Understand medications, learn about potential side effects and discover generic options
- Develop healthy habits with simple tips to help you stay on track
- Explain routine screening or immunizations based on your age and overall health

The SilverSneakers® Fitness Program

SilverSneakers® Fitness Program is here to help you enjoy a lifestyle of fitness, fun and friends. Spending time with people who share your interest in healthy living makes it easier to stay on track toward your fitness goals. This program is available to you for no additional cost.

SilverSneakers Steps is a personalized fitness program for members who don't have convenient access to a SilverSneakers location (nearest location is 15 miles or more from your home). After signing up as a Steps member on www.silversneakers.com/member, you'll receive a kit with tools to help you get fit wherever you are.

When you enroll in the SilverSneakers Fitness Program, you have a fitness membership that includes:

- fitness equipment, treadmills and free weights
- SilverSneakers fitness classes, including YogaStretch and SilverSplash, designed specifically for older adults and taught by certified instructors
- a designated on-site staff member to help you along the way

Solutions for Caregivers

This program is designed to support family caregivers in helping aging family members stay healthier, function as independently as possible and live with dignity. Caregivers are given assistance in maintaining their own health, mitigating stress and caregiver burnout and maximizing available community resources and support.

Treatment Decision Support

Registered Nurses with specialized training will assist retirees in making care decisions. Members will receive help in selecting appropriate treatment and accessing cost-effective care.

Housecalls

Housecalls offers a unique, innovative and highly successful care coordination service to retiree members.

- Personalized in-home visits by health care practitioners to assess the member's health conditions
- Enhance the member's experience and improve quality of care
- Refer members into care management programs as needed

Contact Information

Questions or concerns? Keep these phone numbers as a handy future reference.

UnitedHealthcare

1-877-714-0178 TTY: 711

Please note: The phone number listed above is available to you for any initial questions you may have prior to your effective date.

Please note that once your coverage is activated, future questions or concerns should be raised to the customer service phone number on the back of your ID card or the phone number listed below.

UnitedHealthcare Customer Service

1-800-457-8506 TTY: 711

Monday - Friday 8 a.m. to 8 p.m.

Medicare

1-800-MEDICARE (1-800-633-4227)

TTY/TDD 1-877-486-2048

Seven days a week, 24 hours a day

www.medicare.gov

Finding a UnitedHealthcare Group Medicare Advantage PPO Provider

To help you locate a participating provider, call your plan's Customer Service phone number on the back of your ID card during regular business hours.

Search the online Provider Directory at www.UHCRetiree.com. This directory is updated regularly to provide you with a current list of network providers. You also have the flexibility to see doctors that are not in our network.

NOTE: If you sign up for any Medicare Advantage Plan (other than Senior Advantage offered by Kaiser or UnitedHealthcare Group Medicare Advantage PPO that may be offered to you directly by various vendors, YOUR COVERAGE THROUGH THE CITY OF ATLANTA WILL BE TERMINATED. If you have any questions about this, please call the DHR – Employee Benefits at (404) 330-6036 before signing up for another plan.

Kaiser Permanente Senior Advantage HMO User Guide (Medicare Eligible)

09/01/2014 – 08/31/2015

Complete. Simple. Affordable. Now That's a Senior Advantage

Complete

When you join Kaiser Permanente Senior Advantage, you'll get high quality, personalized care from an award-winning medical group. You'll also love the timesaving convenience of our medical centers. And, you'll have the tools you need to help keep you healthy, like access to 24-hour health coaches or nurse advice, discount on health-related services, online self-help tools, health classes, and more.

SilverSneakers

SilverSneakers® is one of the benefits you'll receive when you join Kaiser Permanente Senior Advantage. As a SilverSneakers Fitness Program member, you'll have access to more than 11,000 fitness locations across the country, where on-site staff members are available to help you meet your personal wellness goals. Many locations offer amenities such as exercise equipment, pools, saunas, SilverSneakers fitness classes, and other fun classes and activities. Other types of fitness locations may also be available in your area. Visit silversneakers.com to find your closest location.

Affordable

You'll enjoy a plan that is simple to understand and simple to use

- One low monthly premium pays for all your coverage.
- No claims to file.

How do I choose or change my primary care physician?

We ask you to choose a personal physician upon enrollment so that you and your doctor can develop a partnership and work together to make sure you get the quality care you deserve. Your personal physician will guide and coordinate any care you receive in the hospital or from specialists. And having one doctor who arranges your care and knows your medical history helps you get the right care from the right people.

The relationship you build with your personal physician can help you achieve and maintain both good health and good spirits. You may choose a physician in family medicine, general practice, adult medicine or pediatrics/adolescent medicine as a personal physician. (Go to www.kp.org for specifics.)

Simply call our Customer Service Department at (404) 233-3700 locally or (800) 611-1811 long distance.

How do I make an appointment?

It's really easy. There is one number to call to make or cancel appointments, speak with an advice nurse, or access after-hours urgent care—regardless of which Kaiser Permanente Medical Center you use. Call the Health Line at (404) 365-0966 locally or (800) 611-1811 long distance. (TTY: 800-255-0056).

To schedule or cancel appointments, you may call Monday through Friday from 7 a.m. to 7 p.m. The Health Line is open to speak with an advice nurse 24 hours a day, seven days a week. You may schedule or cancel appointments by logging on to kp.org.

What if I need to see a specialist?

No referral is required for specialty services available at the Kaiser Permanente medical centers. A referral is required for specialty care outside of a Kaiser Permanente medical center.

Referral specialists are listed in your Kaiser Permanente Senior Advantage HMO Physician Directory.

As a Kaiser Permanente member, you have direct access to Audiology, Behavioral Health, Breast Care, Cardiology, Dermatology, Endocrinology, Gastroenterology, General Surgery, Infectious Disease, Nephrology, Neurology, Obstetrics/ Gynecology, Oncology, Otolaryngology (ENT), Perinatology, Podiatry, Psychiatry, Pulmonology, Rheumatology, Urogynecology, Urology, Wound Care, and Pain Management

What if I need to be admitted to the hospital?

Kaiser Permanente is affiliated with some of Atlanta's most prestigious hospitals. The personal physician you choose will determine the hospital to which you will be admitted. The hospitals used for most inpatient care are: Children's Healthcare of Atlanta at Scottish Rite, Emory Eastside Medical Center, Northside Hospital and Piedmont Hospital.

Get Connected.

Take a minute to register on www.kp.org and enjoy the 24-hour convenience of these secure online features:

- Order prescription refills*
- Request or cancel routine doctors' appointments*
- Get personalized plans for losing weight, managing stress, and eating healthy
- Online total health assessment as well as healthy living classes

You'll also have online access to these new, timesaving features:*

- E-mail your doctor's office
- View certain lab tests results
- Monitor your ongoing health conditions
- Review past office visit information
- And more!

It's simple. To register, visit www.kp.org/register.

*Available for members receiving care/refilling prescriptions at Kaiser Permanente medical centers.

What should I do if I need emergency care?

If you have an emergency, call 911 or go to the nearest emergency room.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

If you are hospitalized, you should call (or have someone else call) the Kaiser Permanente Health Line – (404) 365-0966 locally or (800) 611-1811 long distance – to notify us of your hospital admission as soon as you can within 24 hours of your admission. (TTY: 800-255-0056). This will allow us to consult with the physician providing your care and to coordinate further medical care.

You will pay a $50 copayment for emergency room services. (Emergency fees are waived if you're admitted.) Students attending school outside of the Kaiser Permanente service area will be covered for up to $1,000 for follow-up care associated with emergency services. You are responsible for 20% of the cost up to $1,000 for follow-up emergency care.

Do I fill out claim forms?

There are no claim forms required if care is provided, prescribed, or directed by a Kaiser Permanente physician. If there is a copayment, coinsurance, or deductible, you will be expected to pay at the time you receive the services.

If you have any questions about claims, please call a Claims Services Representative at (404) 365-0966. (TTY: 800-255-0056).

What if I have additional questions?

Call Senior Advantage Customer Services Department from 8:30 a.m. to 5 p.m., Monday through Friday, at (404) 233-3700 or (800) 232-4404, or (800) 255- 0056 (TTY for the hearing and speech impaired). You can also visit our website at www.kp.org.

Note: Retirees and/or their spouses covered by Parts A & B of Medicare who enroll with Kaiser Permanente are only eligible for Senior Advantage. Other family members may enroll in the HMO plan. When joining Kaiser Permanente Senior Advantage, you must complete a separate application. When/if you terminate your Kaiser Senior Advantage, you must complete a Medicare disenrollment form.

Additional Information

The following is a partial list of exclusions and limitations under this plan:

- Services that are not medically necessary;
- Certain exams and other services required for obtaining or maintaining employment or participation in employee/retiree programs, or required for insurance or licensing, or on court order or for parole or probation;
- Cosmetic services;
- Custodial or intermediate care;
- Services that an employer is required by law to provide;
- Experimental or investigational services;
- Eye surgery, including laser surgery, to correct refractive defects;
- Services that a government agency is required by law to provide;
- Services for conditions arising from military service;
- Services related to the treatment of morbid obesity (except certain health education programs are covered);
  - Routine foot care;
  - Sexual reassignment services;
  - Non-human or artificial organs or their implantation;
  - Reversal of voluntary infertility;
  - Transportation and lodging expenses;
  - Conditions covered by workers' compensation or under employer liability law;
  - Services not generally and customarily available in our service area.

In order for Services to be covered, a Plan Physician must determine that the Services are medically necessary to prevent, diagnose, or treat your medical condition. With the exception of emergency services, all covered Services must be provided, prescribed, authorized, or directed by a Plan Physician. You must receive the Services at a Plan Facility inside our Service Area, except where specifically noted to the contrary in the Evidence of Coverage. Certain covered services require preauthorization by Medical Group.

We use a formulary, which is a listing of medications that our physicians and pharmacists consider to be the most safe, useful and cost-effective ones available. A team of Kaiser Permanente physicians and pharmacists independently and objectively evaluates the scientific literature to identify the FDA-approved drugs best suited to treat specific medical conditions. Coverage for prescription drugs is limited to those drugs that are included on the Kaiser Permanente formulary. For a copy of the formulary brochure or for more information about the exception process, contact Customer Services at (404) 365-0966.

For details on the benefit and claims review and adjudication procedures, please refer to your Evidence of Coverage.

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal. Benefits, formulary, pharmacy network, provider network, premiums, and copay/coinsurance may change on January 1 of each year and at other times in accord with your group's contract with us. The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan. Limitations, copayments, and restrictions apply.

Kaiser Permanente maintains policies regarding the confidentiality, protection, and disclosure of personal health and member identifiable information, including policies related to access to medical records. If you have questions about our policies and procedures to maintain the confidentiality of personal information or would like a more comprehensive notice describing how Kaiser Permanente collects and uses personal information, please call Customer Services at (404) 261-2590.

This plan summary is intended to only highlight some of the principal provisions of the plan. Please refer to the Group Agreement or Evidence of Coverage for further details of the plan or for specific limitations and exclusions.

CIGNA Dental PPO Plan Summary Of Benefits

09/01/2014 - 08/31/2015

Description of Benefits

The City offers the choice of two CIGNA Dental PPO plans (High or Low Option) for you and your eligible dependents. These comprehensive plans are administered by CIGNA Dental.* Most dental services, including preventive care, are covered. The annual dollar maximum for both the High and Low Options is $2,000.

Who Can Provide Services

The CIGNA Dental PPO plan is a preferred provider program. Members can seek care in- or out-of network. Participating CIGNA Dental network dentists have agreed to charge reduced fees for covered services; out-of- network dentists provide services at their usual fees. When you use an out-of-network dentist, you may be billed for the difference between the payment the dentist receives from CIGNA and his/her usual fees.

Proof of Coverage

After enrollment, you will receive a CIGNA Dental PPO ID card. However, the ID card is not required to access care.

Claims

Most network dentists will file claims on your behalf; out-of-network dentists may ask you to file the claim. CIGNA Dental will determine benefits, and payment will be made to the dentist or to you based on what is indicated on the claim form. Generally, you or your dentist should receive reimbursement in about three weeks.

How to Obtain Assistance

Help is only a phone call away! If you have questions about the dental plans, want to know the status of a claim, or need to know if specific services are covered, you can contact CIGNA Dental Member Service toll-free at 1-800-CIGNA24 (1-800-244-6224). You can also access personalized dental plan information when you register at www.myCIGNA.com. Through myCIGNA.com, you can:

- Review your dental benefit plan information, including individual and family maximums and deductibles
- Find network dentists through the on-line provider directory
- Check on the status of a claim
- Access dental health news and information from trusted sources
- Print Dental ID cards

How to Appeal Claims

If you disagree with the processing of your claim, you have the right to ask for a review of the claim. Please refer to the “Right to Appeal” section of your benefit booklet for details.

Orthodontics in Progress

"Orthodontics in progress" refers to orthodontic care in progress at the time your dental coverage becomes effective. If your dependent is in the midst of orthodontic treatment when you join the plan, you may be eligible for some contribution.

Your CIGNA Dental PPO plan provides an orthodontic benefit; it covers orthodontics in progress, subject to your plan limitations. The orthodontics in progress benefit is calculated based on the coinsurance level for orthodontic treatment and the number of months of treatment remaining after your effective date. Benefit amounts are payable up to the lifetime dollar maximums or until the treatment is completed, which ever comes first.

Your CIGNA Dental PPO plan also covers orthodontics for new members who are in treatment prior to enrollment. Treatment will become effective the date the retiree becomes effective. The original treatment must be submitted by the provider, which should include the total months of treatment, total fee (including retention) and the banding date. The contracted rate will be paid for the remaining months of treatment until the lifetime maximum has been met or until the treatment is completed, whichever comes first.

The patient balance due on the EOB will be incorrect because CIGNA will only be responsible to pay up to the PPO contracted amount for the remaining months of treatment. However, the patient will be liable for the provider's original case fee because that was the original financial agreement between the patient and provider.

Dental Network Savings Program (DNSP)

Using an out-of-network dental health care professional will cost you more than using in-network care. You may be able to save some money on out-of-pocket expenses if you use a dental health care professional that participates in CIGNA's Dental Network Savings Program.

CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc., and its operating subsidiaries. The CIGNA Dental PPO is underwritten or administered by Connecticut General Life Insurance Company with network management services provided by CIGNA Dental Health, Inc., and certain of its operating subsidiaries.

Summary of Benefits

Here is a summary of benefits for your Dental PPO plan. All deductibles, plan maximums, and service-specific maximums (dollar and occurrence) cross-accumulate between in- and out-of-network. Coverage under the plan is subject to certain limitations and exclusions; see the Summary Plan Description or Plan Document for details.

Benefits	CIGNA Dental High PPO		CIGNA Dental Low PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Maximum (Class I, II, and III expenses)	$2,000	$2,000	$2,000	$2,000
Calendar Year Deductible (individual/family)	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Class I Expenses – Preventive & Diagnostic Care • Oral exams • Cleanings (1 per 6-month consecutive period) • Bitewing X-rays • Fluoride application • Sealants • Space maintainers (*limited to non-orthodontic treatment)* • Full mouth X-rays • Panoramic X-rays	100% No deductible	100% No deductible Subject to reasonable and customary allowances.	100% No deductible	100% No deductible Subject to reasonable and customary allowances.
Class II Expenses – Basic Restorative Care • Emergency care to relieve pain • Fillings • Oral surgery – simple extractions • Oral surgery – all except simple extraction • Surgical extraction of impacted teeth • Osseous Surgery • Periodontal Scaling and Root Planing* • Root canal therapy/Endodontics	80% after deductible	80% after deductible Subject to reasonable and customary allowances.	80% after deductible	80% after deductible Subject to reasonable and customary allowances.
Class III Expenses – Major Restorative Care • Anesthetics • Denture relines, rebases, and adjustments • Repairs – bridges, crowns and inlays • Repairs – dentures • Crowns • Dentures • Bridges • Histopathologic exams • Prosthesis Over Implant	50% after deductible	50% after deductible Subject to reasonable and customary allowances.	50% after deductible	100% after deductible Subject to reasonable and customary allowances.
Class IV Expenses – Orthodontia Coverage for eligible children and adults	50% No separate deductible $1,500 lifetime max		Not covered	
Class V Expenses – TMJ $1,000 lifetime maximum	50% after deductible		50% after deductible	
Missing Tooth Provision	Teeth missing prior to coverage under the CIGNA Dental plan are not covered.		Teeth missing prior to coverage under the CIGNA Dental plan are not covered	
Pretreatment Review	Available on a voluntary basis when extensive work in excess of $500 is proposed.		Available on a voluntary basis when extensive work in excess of $500 is proposed.	
Out-of-Network Reimbursement	80th percentile of reasonable and customary allowances		80th percentile of reasonable and customary allowances	
Student Age	26		26	

*Periodontal coverage has a separate $1,000 lifetime maximum.

Humana Specialty Benefits Dental Access Plan

09/01/2014 - 08/31/2015

Welcome to ***Dental Access***

Humana Specialty Benefits is pleased to offer you and your family an innovative option in dental benefits called *Dental Access*. Preventive dental care is an important part of everyone's health care needs. *Dental Access* is designed to meet your needs by providing affordable coverage and reducing the cost associated with maintaining good dental health.

Dental Access Offers:

Access

- Freedom to use any dentist with benefit incentives to use participating network providers
- Freedom for each family member to have their own dentist
- Immediate access to Specialists at fixed copayments
- No referral required for specialty care

Savings

- No deductibles
- Fixed member in-network copayments with no balance billing
- Scheduled reimbursement for out-of-network dental services
- No benefit waiting periods

Convenience

- No claims forms for in-network services
- No pre-authorization needed to change dentist or to use non-participating providers

Dental Access provides the protection, flexibility and the coverage you and your family desire. The plan offers both in-network and out-of-network benefits, that gives you and your family the ability to receive care from any dentist in the community. While most of the time there will be higher out-of-pocket costs for care obtained out-of-network, the plan provides you the comfort of having this flexibility.

In-Network Coverage

Private practice dentists who contract with Humana Specialty Benefits provide treatment and services for you and your family. These dentists agree to provide the comprehensive benefits outlined in your dental plan and to accept the Humana Specialty Benefits fee schedule. Upon enrolling in the plan, you may seek treatment from any dentist listed in the network directory. Your dentist will charge specific copayments for covered procedures. This means fewer out-of- pocket expenses for you when using your in-network coverage. See the Schedule of Benefits for exact copayments and reimbursements per dental procedure.

The In-Network Advantage

- Preventive and diagnostic services covered at 100 percent, including routine cleanings, examinations, X-rays, fluoride treatments and emergency palliative treatment (office visit copayment may apply)
- Coverage for restorative and specialty care with fixed copayments
- Flexibility to choose any network dentist at any time
- Family Choice, which allows each family member to select a different general care dentist
- Immediate specialty access
- Quality assessment of participating dental offices

Humana Specialty Benefits is very concerned with providing you and your family with access to quality care and therefore takes the appropriate measures to verify the professional credentials of dentists applying for participation in the Humana Specialty Benefits network. On-site quality assurance inspections are performed on participating dental offices on an annual basis.

Out-Of-Network Coverage

If you should decide to seek services outside of Humana Specialty Benefits' network of participating dental providers, you would simply receive dental care from any licensed, practicing dentist. You would pay for the treatment rendered, complete a claim form, and submit the form to Humana Specialty Benefits for direct reimbursement to you of approved claims.

There are no deductibles or waiting periods to receive coverage. Refer to Benefits, Limitations and Exclusions for a detailed review of benefits. **A fixed dollar amount is reimbursed on each procedure. The applicable Preventive & Diagnostic Office Visit Copayment is deducted from the maximum reimbursement amount for preventive and diagnostic procedures.**

Your responsibility under this option includes any cost that remains after the insurance reimbursement and maximum benefit limitations. Your plan also covers a portion of the cost associated with emergency dental care that you may receive from a non-participating provider.

Benefit Summary

Below is a brief summary of the dental benefits under the DENTAL ACCESS plan. This is provided as an overview document. Details about your coverage are outlined in your Schedule of Dental Benefits. Should there be any difference between this summary and the Benefits Schedule, the terms and conditions of the Benefits Schedule will prevail.

DENTAL ACCESS		
	In-Network	Out-of-Network
Benefit Level	See Benefit Schedule	See Benefit Schedule
Preventive & Diagnostic Office Visit Copay	None	None
Annual Deductible	$0	$0
Annual Benefit Maximum	Unlimited	Unlimited
BENEFIT SUMMARY FOR COVERED DENTAL SERVICES		
	You pay Humana Specialty Benefits Provider:	Humana Specialty Benefits reimburses you:
Preventive & Diagnostic Services		
Periodic oral examination*	No charge	$24
Bitewing X-rays – four*	No charge	$27
Panoramic film*	No charge	$50
Prophylaxis – adult*	No charge	$45
Prophylaxis – child*	No charge	$30
Fluoride – child (including prophylaxis)*	No charge	$35
Sealants (permanent molars only)*	No charge	$23
Basic Services		
Amalgam filling – two surface	$0	$52
Composite filling – two surface anterior	$0	$52
Prefabricated steel crown – primary	$90	$19
Pulp cap – direct (excluding final restorations)	$0	$23
Root canal – bicuspid	$0	$289
Scaling and root planing – per quad (4+ teeth per quad)*	$0	$79
Major Services		
Crown – porcelain fused to noble metal	$354	$136
Complete full upper dentures*	$472	$132
Orthodontic Coverage		
Children coverage	$3,035 maximum charge from in-network provider	$365 out-of-network coverage
Adult coverage	$3,325 maximum charge from in-network provider	$165 out-of-network coverage

Services indicated with an asterisk (*) are subject to frequency and/or age limitations. Consult your Benefits Schedule for a complete list of frequencies, limitations, and exclusions.

This material is a brief outline of benefit and covered services. The full Schedule of Benefits with a complete explanation of services, exclusions, and limitations will be included in your enrollment book.

Humana Specialty Benefits DHMO Dental Program

09/01/2014 – 08/31/2015

Welcome to the Humana DHMO Dental Program – Preselect

Regular professional dental care is important to maintaining healthy teeth and gums. With rising dental fees, it can also be quite expensive. Your selection of the DHMO Dental Program will provide professional dental care while helping you control dental expenses.

If you enroll in dental coverage, you must remain in the program selected for a period of 12 months.

With the DHMO program, you have coverage for preventive, basic and major services, and you can take advantage of:

- Lowest payroll deduction option!
- No deductibles
- No annual maximum
- Generally lower out-of-pocket expenses than a traditional program

(See your Schedule of benefit copayments for more details.)

Choice of Dentists

Humana DHMO contracts with dentists in the community to provide quality care to our members. To receive benefits, you and each of your dependents must select a dental facility from the Humana DHMO list of participating dental offices. Dentists undergo a thorough review process prior to participation in the network. A licensed general dentist and staff of professional auxiliaries operate each office. If you wish, you may select a different dentist for each covered dependent so that each covered dependent can receive dental care where it is most convenient.

Making an Appointment with Your Dentist

You may schedule appointments by calling the dental office you selected after your effective date of coverage. When you call to schedule your appointment, notify the office that you are a member of the Humana DHMO dental plan.

Call (800) 342-5209 if you are not certain about your dental provider selection.

Changing Your Selection of Dentist

Members may wish to transfer to another participating dental office or provider. Transfer requests may be made in writing to Humana or may be requested by calling Humana's Member Support Department at (800) 342-5209. Outstanding balance must be cleared before a transfer request will be honored. Requests received by Humana during the first 15 days of the month will become effective the first of the following subsequent month. Members may not be seen at 2 different participating dental offices during the same one-month period. Humana may open and close enrollment at any participating dental offices and providers from time to time.

Specialist Care

Certain dental procedures require the services of a specialist (i.e. some oral surgery, endodontics, periodontics and pedodontics). In those cases, you must seek treatment from Humana specialty providers to receive appropriate discounted fees. A referral is needed from your general dentist in order to receive services from a specialist in the DHMO network. Access to orthodontic discounts does not require a referral!

United Healthcare Vision Benefits Summary

09/01/2014 – 08/31/2015

Provider Locator

With UnitedHealthcare Vision you are able to choose from network private practice providers and retail chain providers. Prior to enrolling in or using the UnitedHealthcare Vision program, if you would like to identify a network provider, visit UnitedHealthcare Vision's Website – www.myuhcvision.com and provide locator or call UnitedHealthcare Vision's Provider Locator Service at 1-800-839-3242 and follow the voice prompts:

- Enter the primary insured's unique identification number
- Enter the ZIP code for the area you wish to check
- After each entry, the system will repeat what you have entered and ask that you "Press 1" if correct, or "Press 2" if incorrect
- The system will then identify up to three network providers in the requested ZIP code area
- If you wish to hear the selections again, "Press 1". To enter another five-digit ZIP code, "Press 2"

Prior to using your benefits at a network provider, please call the provider and make an appointment. Please inform the provider that you are a UnitedHealthcare Vision participant.

PLEASE NOTE: If there are differences in this document and the Group Policy, the Group Policy is the governing document. Please retain this Benefit Summary and Vision Care Program description that includes detailed benefit information and instructions on how to use the program. Customer Service is available toll-free at 1-800- 638-3120 from 8:00 a.m. to 11:00 p.m., Monday through Friday, and from 9:00 a.m. to 6:30 p.m. on Saturdays.

ID cards will be issued to all enrollees or may be obtained online.

Important to Remember

- Always identify yourself as a UnitedHealthcare Vision participant when making your appointment. This will assist your provider in obtaining a claim authorization number prior to your visit.
- Benefits available every 12 months, based on last date of service.
- Your $150 contact lens allowance is applied to the fitting/ evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is $30, you will have $120 towards the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store. Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.

The following services and materials are excluded from coverage under the Policy:

1. Post cataract lenses
2. Non-prescription items
3. Medical or surgical treatment for eye disease, that requires the services of a physician
4. Worker's Compensation services or materials
5. Services or materials that the patient, without cost, obtains from any governmental organization or program
6. Services or materials that are not specifically covered by the Policy
7. Replacement or repair of lenses and/or frames that have been lost or broken
8. Cosmetic extras, except as stated in the Policy's Table of Benefits

Benefits At A Unitedhealthcare Vision Network Provider	
Comprehensive Vision Exam ($15 copay; Once Every 12 Months)	A vision examination is provided by a network optometrist or ophthalmologist, after applicable copay.
Materials ($25 copay)	The materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses.
Pair Of Lenses (for eyeglasses) (Once Every 12 Months) • Standard single vision • Standard lined bifocal • Standard lined trifocal • Standard lenticular	Standard scratch-resistant coating, tints and UV are covered-in-full. **Lens Options** – Options such as progressive lenses, polycarbonate lenses and anti-reflective coating may be available at a discount.
Frames (Once Every 12 Months)	$130 frame allowance at both private practice and retail providers.
Contact Lenses (in lieu of eyeglasses) (Once Every 12 Months) • Covered-in-full elective contact lenses • All other elective contacts • Necessary contact lenses*	The fitting/evaluation fees, contacts (including disposable s), and up to two follow-up visits are covered-in-full (after applicable copay) for many popular brands, such as Acuvue by Johnson & Johnson and Optima by Bausch & Lomb. If covered disposable contact lenses are chosen, up to 6 boxes (depending on prescription) are included when obtained from a network provider. It is important to note that UnitedHealthcare Vision's covered-in-full contact lenses may vary by provider. A $150 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside of UnitedHealthcare Vision's covered-in-full contacts (materials copay does not apply). Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection. Necessary contact lenses are covered in full after applicable copay
Laser Vision Benefit	UnitedHealthcare Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off usual and customary pricing, 5% off promotional pricing at over 500 network provider locations and even greater discounts through set pricing at Lasik Plus locations. For more information, call (888) 563-4497 or visit us at www.uhclasik.com.

Benefits At An Out-of-Network Provider		
Service	**Amount**	If you choose an out-of-network provider, you will need to send your itemized receipts, with the primary-insured's unique identification number and the patient's name and date of birth, to: UnitedHealthcare Vision P. O. Box 30978 Salt Lake City, UT 84130 Fax: (248) 733-6060 **Please note:** Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.
Exam		
• Optometrist	Up to $40	
• Ophthalmologist	Up to $40	
Lenses		
• Single Vision	Up to $40	
• Bifocal	Up to $60	
• Trifocal	Up to $80	
• Lenticular	Up to $80	
Frames	Up to $45	
Contact Lenses (in lieu of eyeglasses)		
• Elective	Up to $150	
• Necessary*	Up to $210	

**Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery; To correct extreme vision problems that cannot be corrected with spectacle lenses; With certain conditions of anisometropia; With certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision concerning the reimbursement that UnitedHealthcare Vision will make before you purchase such contacts.*

Retiree Life Insurance

09/01/2014 – 08/31/2015

Open Enrollment Changes

You make a great investment in your family. You spend time with them. You care for them, and if you're not there for them, you want them protected. As a City of Atlanta retiree receiving a pension benefit, you are eligible for life insurance coverage.

The following is an outline of the Life Insurance benefits that are available. This information is provided as an overview and does not constitute a contract. Please refer to the Life Insurance policy for detailed explanation of policy provisions.

Eligibility

To be eligible for this plan:

- You must be a retiree of the City of Atlanta or a widow(er) of an employee or retiree covered by the insurance at the time of your spouse's death.
- You must have had life insurance coverage as an active employee at the time of retirement.
- For Dependent Life insurance your spouse or children must not be full-time members of the armed forces of any country.
- A widow(er) cannot cover dependents.

Retiree/Widow(er) Coverage Amount

- $5,000
- Some grandfathered employees may have different amounts.
- A retiree or widow(er) who terminates his/her coverage is not eligible to return to the City plan in the future.

Additional Life Insurance Coverage

City of Atlanta retirees (only) can purchase up to $20,000 in additional life insurance coverage directly from Minnesota Life Insurance Company. Retirees will be responsible for paying life insurance premiums directly to Minnesota Life. Please contact Minnesota Life directly at (800) 660-2519. Retirees will be responsible for all premium payments for this additional coverage, above the flat $5,000 coverage amount or coverage for retirees with grandfathered life insurance. The additional coverage can be purchased with options of $5,000, $10,000, or $15,000 amounts.

Spouse and Dependent Coverage Amount

- Dependents Life Insurance is also available and would provide the following coverage:
  - Spouse: $5,000
  - Child between birth and six months: $600
  - Child between six months and 26 years: $5,000
- All late applications will require medical underwriting approval by Minnesota Life.
- A Surviving Spouse who is insured at the time an Employee or Retiree passes away will be eligible to continue his/her $5,000 Life Insurance coverage.

Beneficiary Designation Change

You may change your beneficiary at any time during the year by completing a Beneficiary Change form and submitting it to the DHR – Employee Benefits.

If You Have Questions

If you have any questions about eligibility enrollment or life insurance coverage, contact the DHR – Employee Benefits at (404) 330-6036.

Minnesota Life Insurance Company

Minnesota Life Insurance Company Minnesota Life is one of the country's largest group life insurers.

We understand the important role we play in the financial wellbeing of the millions of employees we insure nationwide, and will be there when you need us most.

We are among the highest rated group life insurance companies according to the independent rating agencies that analyze the financial soundness and an insurance company's ability to pay claims. For more information about the rating agencies and to see how we compare to other companies, please visit www.securian.com/financials.

Cost of Coverage

You and the City of Atlanta share the cost of your life insurance coverage. The City pays for $1.93 per $1,000 of benefit and you pay $0.82 per $1,000 of benefit. The City does not contribute toward the cost of Dependent Life Insurance and Additional Life Insurance. Your cost for life insurance is as follows:

Amount of Insurance	**You Pay**	**The City Pays**
$5,000	$4.12	$9.63

For grandfathered retirees with Frozen Plans elected prior to May 31, 1967, that have amounts over $5,000, the cost of coverage is listed below.

Amount Of Insurance	You Pay	The City Pays
$6,000	$4.98	$11.58
$7,000	$5.81	$13.51
$8,000	$6.64	$15.44
$9,000	$7.47	$17.37
$10,000	$8.30	$19.30

Note: All other retirees have a flat $5,000 benefit amount.

Dependents Plan

Amount of Insurance
- Grandfathered Retiree: $10,000
- Spouse: $5,000
- Children Birth – six months: $600
- Children six months – 26 years: $5,000
- Surviving Spouse (if enrolled prior to the employee passing away): $5,000

Retiree Monthly Premium
- Grandfathered Retiree: $8.25
- Spouse: $4.00
- Child: $1.19

Surviving Spouse Monthly Premium
$20.00

A RETIREE OR WIDOW(ER) WHO TERMINATES HIS/HER COVERAGE IS NOT ELIGIBLE TO RE-ENROLL IN THE CITY PLAN IN THE FUTURE.

City of Atlanta retirees (only) may purchase up to an additional $20,000 in basic life insurance coverage directly through Minnesota Life Insurance. All coverage over the flat $5,000 benefit amount above will be the responsibility of the retiree. The City will not make any contribution for coverage above the flat $5,000 benefit amount. Please contact Minnesota Life Insurance Company at (800) 660-2519.

Glossary

Application: A signed statement of facts requested by the company on the basis of which the company decides whether or not to issue a policy. This then becomes part of the health insurance contract when the policy is issued.

Approved Amount: The amount determined by the Medicare carrier to be reasonable and fair for each service.

Beneficiary: The person designated or provided for by the terms to receive the proceeds upon the death of the insured.

Benefit Package: A collection of specific services or benefits that the HMO and Indemnity is obligated to provide under terms of its contracts with subscriber groups or individuals.

Benefit Period: The period of time during which benefits are available, such as a year or for the lifetime of the contract.

Benefits: The amount payable by an insurance company for covered services.

Carrier: The insurance company responsible for processing claims; it may perform the carrier function on its own behalf, or for another entity who pays losses; under the Medicare program, for example, the Social Security Administration selects private insurance companies to administer Part B claims.

Claim: A demand to the insurer for the payment of benefits under the insurance contract.

Coinsurance: The fixed percentage of covered charges you must pay after any deductible has been subtracted. For example, if a plan pays 80 percent of covered charges (after applying any deductible), you would be responsible for the deductible and the 20 percent balance.

Consumer Choice Option (CCO): A health plan mandated in 1999 by the Georgia General Assembly. This plan allows members to nominate a non-network provider that will act as a part of the net-work. An employee who has selected the CCO may elect a qualified provider to render any covered services. Member is subject to normal rules and conditions that apply to a contracted network provider, i.e., reimbursement, usual customary and reasonable costs, and prescription drugs. Members will incur additional costs if they choose the CCO health plan.

Contingent Beneficiary: Person named to receive proceeds or benefits should an unforeseen event prevent the named Primary Beneficiary(ies) from collecting benefits (or insurance).

Conversion Privilege: A privilege granted in an insurance policy to convert to a different plan of insurance without providing evidence of insurability. The privilege granted by a group policy is to convert to an individual policy upon termination of group coverage.

Coordination of Benefits: Establishes procedures to be followed in the event of duplicate coverage thus assuring that no more than 100 percent of the costs of care are reimbursed to the patient.

Copayment: A fixed dollar amount you must pay for a service or benefit provided by a plan.

Coverage: The amount or extent to which any particular treatment or service is insured by a health provider.

Deductible: The amount of covered charges you must pay before the plan pays benefits, for example, calendar-year deductible and inpatient hospital deductible. Generally, no more than two or three family members must meet the calendar-year deductible. However, some plans have a family calendar-year deductible, which can be met by any or all of those covered.

Dental Care: Coverage may include routine diagnostic and preventive services and one or more of the following treatment services: restorative, crown and bridge, endodontic, oral surgery, periodontal, prosthetic, and orthodontic. Some prepaid plans (DMOs) limit coverage to preventive services for children.

Disability: A limitation of physical or mental functional capacity resulting from sickness or injury. It may be partial or total. (See also Partial Disability and Total Disability.)

Domestic Partnership: A union in which two individuals (unrelated by blood) of the opposite or same sex choose to share their lives in a close and committed relationship of mutual caring; who live together and have signed a Declaration of Domestic Partnership in which they have agreed to be jointly responsible for basic living expenses incurred during the Domestic Partnership.

Effective Date: The date on which the insurance under a policy begins.

Eligibility Period: A specified length of time, frequently 30 days following the eligibility date during which an individual member of a particular group will remain eligible to apply for insurance under a group life or health insurance policy without evidence or insurability.

Eligible Date: The date on which an individual member of a specified group becomes eligible to apply for insurance under the (group life or health) insurance plan.

Eligible Employees: Those members of a group who have met the eligibility requirements under a group life or health insurance plan.

Evidence of Insurability: Any statement of proof of a person's physical condition and/or other factual information affecting his/her acceptance for insurance.

Exclusions: Charges, services, or supplies that are not covered. A plan does not provide or pay for excluded items, nor do charges for them apply toward deductibles and catastrophic limits.

Flexible Spending Account (FSA): A benefit option that reimburses employees for certain expenses they incur. Money is deducted from paychecks on a pre-tax basis. It most often covers reimbursements for medical expenses not covered under other insurance, or childcare expenses.

Grace Period: A specified period – thirty-one days – after a premium payment is due, in which the policyholder may make such payment, and during which the protection of the policy continues.

HCFA: Health Care Financing Administration. The agency of the U.S. Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs.

HIPAA: Health Insurance Portability and Accountability Act of 1996. A federal law which requires employers to provide certificates of coverage to minimize pre-existing condition exclusions.

Health Insurance: Protection that provides payment of benefits for covered sickness or injury. Included under this heading are various types of insurance such as accident insurance, disability income insurance, medical expense insurance, and accidental death and dismemberment insurance.

Health Maintenance Organization (HMO): An organization that provides a wide range of health-care services for a specified group at a fixed periodic payment. The HMO can be sponsored by the government, medical schools, hospitals, employers, labor unions, consumer groups, insurance companies, and hospital-medical plans.

Hospice Care: A coordinated program at home and/or on an inpatient basis, offering easing of the patient's pain and discomfort, and providing supportive care, for a terminally ill patient and the patient's family, provided by a medically supervised specialized team under the direction of a licensed or certified hospice-care facility or agency.

In-Network Provider: Selected physicians who furnish a comprehensive array of healthcare services. Under contractual agreement, doctors accept the insurance carriers "Usual, Customary and Reasonable" amounts, as payment-in-full.

Inpatient Services: The care provided while a bed patient is in a covered facility. Provides extra benefits for services not covered at all by the base plan, and that in some cases pays balances of services not covered completely by the base plan; most are characterized by large benefit maximums, ranging from $250,000 to no limit; above an initial deductible, major medical reimburse the major percentage of all charges for hospital, doctor, private nurses, and so on; the policyholder insurer pays the remaining co-insurance.

Managed Care: Health-care systems that integrate the financing and delivery of appropriate health-care services to covered individuals by arrangements with selected providers to furnish a comprehensive set of health-care services, explicit standards for selection of healthcare providers, formal programs for ongoing quality assurance and utilization review and significant financial incentives for members to use providers and procedures associated with the plan.

Medicaid: State programs of public assistance to people, regardless of their age, whose income and resources are insufficient to pay for health care. Title 19 of the federal Social Security Act provides matching federal funds for financing state Medicaid programs, effective January 1, 1966.

Medicare Supplements (Medigap): Policies sold by insurance companies that help supplement the amounts not paid by the Medicare program for covered services.

Medicare: The government health insurance system for people over the age of 65 (and for certain other groups), created by the 1965 amendments to the Social Security Act. This includes new coverage for prescription drugs under Medicare Part D.

Miscellaneous Expenses (Ancillary Charges): Hospital charges (other than room and board) such as for x-rays, drugs, and laboratory fees.

Open Enrollment Period: The period of time stipulated in a group contract in which eligible of the group can choose a health plan alternative for the coming benefit year.

Out-of-Area Benefits: The scope of emergency benefits (and related limitations) available to HMO members while temporarily outside their defined service areas. Some HMOs offer unlimited out-of-area emergency coverage. Others impose a stated maximum annual dollar benefit. Emergency coverage is usually the only HMO benefit in the total benefit package for which members may need to file claim forms for reimbursement of their out-of-pocket expenditures for care.

Out-of-Network Providers: Physicians who do not participate in a contractual relationship to provide services and care for a predetermined amount to a carrier's member.

Outpatient Services: The care provided to you in the outpatient department of a hospital, in a clinic or other medical facility, or in a doctor's office.

Partial Disability: The result of an illness or injury that prevents an insured from performing one or more of the functions of his or her regular job.

Participating Physician: A doctor or supplier who agrees to accept Medicare assignment on all claims under the Medicare program. Agreement by which, under the contractual agreement, the doctors accept the insurance carriers usual, customary, and reasonable amount as payment in full.

Point-of-Service (POS): This product may also be called an open-ended HMO and offers a transition product incorporating features of both HMOs and PPOs. Beneficiaries are enrolled in an HMO but have the option to go outside the network for an additional cost.

Preadmission Certification: A procedure whereby (1) you or your doctor is required to contact your plan before your admission to a hospital, and (2) your plan determines the appropriateness of the admission and the length of stay by using established medical criteria.

Preexisting Condition: A physical and/or mental condition of an insured that first manifested itself prior to the issuance of his or her policy or that existed prior to issuance and for which treatment was received.

Preferred Provider Organization (PPO): A group of physicians and/or hospitals who contract with an employer to provide services to their employees. In a PPO the patient may go to the physician of his/ her choice, even if that physician does not participate in the PPO, but the patient receives care at a lower benefit level.

Premium: The fee you must pay (monthly, biweekly, quarterly) on a regular basis for your enrollment in a plan.

Prescription Drugs: Outpatient drugs and medicines which, by United States law, cannot be obtained without a doctor's prescription.

Primary Care Network: The structure for these networks will vary considerably depending on the specific network. It may range from a loose association of physicians in a geographic area with a limited sharing of overhead, patient referral, call, etc. to a more structured association with commonly owned satellite clinics, etc.

Primary Care Physician (PCP): Provide treatment of routine injuries and illness and focuses on preventative care. Serves as gatekeeper for managed care. The American Academy of Family Practice defines primary care as "care from doctors trained to handle health concerns not limited by problem origin, organ systems, gender or diagnosis.

Prior Authorization: Procedure used in managed care to control utilization of services by prospective reviewing and approval.

Providers: Those institutions and individuals who are licensed to provide health care services (for example, hospitals, skilled nursing facilities, physicians, pharmacists, etc.). Providers in a defined service area are principally owned by, affiliated with, employed by, or under contract to an HMO.

Service Area: The geographic area where prepaid plan (HMO) providers and facilities are available to you. This area would be the same as, or within, the plan's enrollment area.

Total Disability: An illness or injury that prevents an insured person from continuously performing every duty pertaining to his or her occupation or engaging in any other type of work. (This wording varies among insurance companies.)

UCR (Usual, Customary, and Reasonable): A maximum payment allowed for a given medical service based on a statistical formula calculated by an insurance company to determine the amount it will pay on a given medical service.

Waiting Period: The length of time an insured must wait from his or her date of enrollment or application for coverage to the date his or her insurance is effective.

Health Insurance Portability And Accountability Act

Portability Provision

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 provides protection for employees and dependents who have pre-existing medical conditions or might be denied health coverage based on factors related to an individual's health. HIPAA includes changes that:

- Limit Exclusion for pre-existing conditions
- Prohibit discrimination against employees and dependents based on their health status
- Guarantee renewability and availability of health coverage to certain employers and individuals; and
- Protect many workers who lose health coverage by providing better access to individual health insurance coverage

Under HIPAA the employer may impose a pre-existing condition exclusion with respect to an employee, dependent or beneficiary only if the following requirements are satisfied:

- A pre-existing condition exclusion must relate to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6-month period prior to an individual's enrollment date;
- A pre-existing condition exclusion may not last for more than 12 months after an individual's enrollment date; and
- This 12-month period must be reduced by the length of time of the individual's prior creditable coverage, excluding coverage before any break in coverage of 90 days or more

How Portability Affects City of Atlanta Employees

Effective January 1, 1998, you and your dependents did not have to satisfy a pre-existing condition waiting period if you provide certification of prior creditable coverage sufficient to satisfy the respective pre-existing condition waiting periods.

When an Employee Terminates Coverage

HIPAA requires that your Insurance Carrier provide you (and your dependents) with certificates of coverage automatically upon termination of coverage.

Special Enrollment Periods

There are special enrollment periods for you and your dependents who:

- Originally declined coverage because of other coverage, and
- Who exhausted COBRA benefits, lost eligibility for prior coverage, or employer contributions toward coverage were terminated, and
- An individual declining coverage must certify in writing that they are covered by another health program when they initially decline coverage under this group in order to later qualify under this special enrollment. A person declining coverage will be given notice of the consequences when they originally decline coverage.

In addition there are also special enrollment periods for new dependents resulting from marriages, births or adoptions. An unenrolled member may enroll within 31 days of such a special qualifying event.

Important Notes

- Individual or dependents must request coverage within 31 days of qualifying event (i.e. marriages, exhaustion of COBRA, etc.).
- Evidence of prior creditable coverage is required. Please refer to your benefit booklet for more information concerning Portability Provisions and Requirements.

All new hires should submit a copy of the HIPAA Form received from their previous employer to the DHR - Employee Benefits for proper credit.

COBRA Continuation Coverage

Under COBRA—the Consolidated Omnibus Reconciliation Act of 1985, Title X, terminated employees and their eligible dependents may continue group health plan coverage. We urge you to read this description of the "continuation coverage" option carefully, and to make sure you and your spouse read and understand the rights and responsibilities in connection with this continuation of coverage. Both you and your spouse must sign the front page of this enrollment application.

The Benefits

If you are currently covered under The City of Atlanta Health Plan, you will be entitled to continue your and your family's Health Plan coverage for up to 18 months from the date coverage would have terminated because of voluntary or involuntary termination. If a qualified beneficiary is deemed disabled for Social Security, at the date of the qualifying event, or within the first 60 days following the qualifying event, the continuation coverage period is 29 months for all the members of your family who have elected COBRA. The 18-month period may be extended also if other events (such as a death or divorce) occur during that 18-month period. Employees discharged because of "gross misconduct" would not be eligible for continuation of coverage. Dependents who no longer qualify as dependents under the City of Atlanta Health Plan are eligible to apply for continuation of coverage. If you should die or become divorced, and if your spouse and dependents are covered by the City of Atlanta Health Plan at that time, they will be entitled to continue health coverage for up to 36 months. Continuation coverage is also available for your children for up to 36 months. If an Eligible Person is 60 years old on the date COBRA continuation coverage started COBRA coverage may extend up to the time of Medicare eligibility. If you have a new born child, adopt a child or have a child placed in your home pending adoption (for whom you have financial responsibility), while your COBRA continuation is in effect, you may add this child to your coverage.

The Cost

Continuation of coverage is optional on the part of the employee or dependent. Those who elect continuation of coverage will be required to pay 102% of the total monthly group premium for the applicable class of coverage. For the extended disability coverage, employees may be required to pay up to 150% of the monthly group premium for coverage during the 19th through the 29th month. Persons 60 years old on the date of COBRA eligibility may be required to pay up to 120% of the premium for extended time. There will be no contribution made by the City of Atlanta. Premiums are due monthly and in advance. You should note that your continuation coverage will stop if the premiums for this coverage are not paid on time. If you elect to continue coverage new dependents may be added during the period of continuation on the same basis as they are added for active employees. If during continuation of coverage, health benefits and premium rates change, your coverage and costs will be affected accordingly. Should open enrollment occur during the period of your continuation you will retain your right to switch to a different option.

When Coverage Ends

If you or covered members of your family become entitled to Medicare or are covered under another employer-sponsored health plan, which does not limit coverage due to preexisting conditions, the continuation coverage from the City of Atlanta Health Plan will cease. In addition, your coverage will cease if City of Atlanta should terminate the Health Plan or you cease to pay premium. Once the period of coverage continuation has expired, anyone receiving continuation coverage will be eligible to convert to individual policies, as provided under the City of Atlanta Plan.

What You Must Do

You or your spouse or dependents must notify the DHR - Employee Benefits when your dependent child, reaches the maximum age under the Plan, or in the event you become divorced. It is important that you notify us of your or your dependents loss of Plan eligibility promptly–in advance, if possible, but no later than 60 days from the date coverage would otherwise have terminated in order to be eligible to elect continuation coverage. Within 14 days after the end of the month in which you notified the DHR - Employee Benefits, you or your eligible dependents will be mailed information and forms regarding continuation of coverage. You or your dependent must return the completed election forms within 60 days. If continuation of coverage is selected within 60 days you or your dependent will then have an additional 45 days to pay the applicable premium, retroactive to the date coverage would otherwise have terminated. If you would like further information on continuation coverage under the City of Atlanta Health Plan, please contact the DHR - Employee Benefits at (404) 330-6036.

Conversion Privilege

When your group health insurance ends due to termination of employment with the City of Atlanta or due to expiration of COBRA continuation of health care coverage under the group contract you may apply for converted health coverage. For additional information contact the DHR - Employee Benefits (404) 330-6036.

If you terminate your employment with the City, or your COBRA eligibility terminates, A CERTIFICATE OF GROUP HEALTH PLAN COVERAGE will be mailed by your Insurance Carrier/ HMO, to the last address on their file.

If you are a new employee, have previously waived your health insurance, or are adding a dependent other than a new born (or child placed in your home pending adoption), you should provide copies of the CERTIFICATE OF GROUP HEALTH PLAN COVERAGE issued to you or your dependents, by the previous employer(s) for CREDITABLE PRIOR COVERAGE.

City of Atlanta
Department of Human Resources
Employee Benefits
404.330.6036